DOCUMENT RESUME

ED 229 948 EC 151 957

AUTHOR Noel, Margaret M., Ed.; Haring, Norris G., Ed.
TITLE Progress or Change: Issues in Educating the Emotionally Disturbed. Volume 1: Identification and Program Planning.
INSTITUTION Washington Univ., Seattle. Program Development Assistance System.
SPONS AGENCY Office of Special Education and Rehabilitative Services (ED), Washington, DC. Div. of Innovation and Development.
PUB DATE Sep 82
CONTRACT 300-79-0062
NOTE 172p.; For a related document, see EC 151 958.
PUB TYPE Books (010) -- Viewpoints (120) -- Information Analyses (070)

EDRS PRICE MF01/PC07 Plus Postage.
DESCRIPTORS *Administrative Problems; Agency Cooperation; *Behavior Disorders; *Definitions; Delivery Systems; Educational History; Elementary Secondary Education; *Emotional Disturbances; Evaluation Methods; *Handicap Identification; Program Development; Student Evaluation; Student Placement

ABSTRACT

Seven papers focus on issues in identification and educational program planning for children with emotional disturbances. "Social Policy Issues in Special Education and Related Services for Emotionally Disturbed Children and Youth" (J. Kauffman), touches on problems with the federal definition of and terminology about the emotionally disturbed and suggests possible reasons for inadequate services to this population. Two major areas (conceptual and procedural) relating to the assessment of mild behavior disorders in children are examined in "Assessment of Behavior Disorders in the School Setting: Issues, Problems, and Strategies" by H. Walker. Biophysical, psychodynamic, behavioral, sociological, and ecological perspectives in assessment are considered, and a 9-step model is proposed by B. Algozzine ("Assessment of Severe Behavior Disorders"). S. Braaten presents "A Model for the Differential Assessment and Placement of Emotionally Disturbed Students in Special Education Programs," in which data are assigned priority ratings to convey the extent of the student's disturbing behavior. N. Haring reviews historical developments in "Perspectives on the Development of Educational Programs for the Emotionally Disturbed." Interprofessional and interagency collaboration are among the major topics considered in "Cooperative Full Service Delivery to Emotionally Disturbed Students" by F. Wood. Eligibility, placement, discipline (suspension, expulsion, corporal punishment), and related services are covered in "Administrative Issues in Educating Emotionally Disturbed Students in the Public Schools" by B. Tilley, J. Gross, and L. Cox. (CL)

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ED229948

PDAS
Program Development
Assistance System
University of Washington

# Progress or Change:

## Issues in Educating the Emotionally Disturbed

## Volume 1: Identification and Program Planning

Edited by
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EC151957

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This document was produced under contract number 300-79-0062 from the United States Education Department, Special Education Programs, Division of Innovation and Development, Program Development Branch. The opinions expressed herein do not necessary reflect the position or policy of the United States Education Department, and no official endorsement of U.S.E.D. should be inferred.

Printed in the United States of America.

September 1982

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# Preface

Margaret M. Noel
Norris G. Haring

Providing suitable educational facilities for emotionally disturbed children has historically been a problem. These children have presented an anomaly for educators, challenging the categorical distinctions of the educational classification system. In the past, emotionally disturbed children were considered beyond the services of public education, ill-suited for the mediated programs of more severely handicapped students, yet too disruptive for placement in the regular classroom. They have been an underserved population, referred for clinical treatment of their emotional conflicts, often at the expense of their education.

In the last two-and-a-half decades, the availability of educational facilities for this group has increased. Based on the premise that ". . . what is good for educational progress is also good for social and emotional growth" (Haring & Phillips, 1962, p. 2), educational programs became the basic "therapy" provided to these students. Rather than establish clinical remediation of behavioral problems as an antecedent to education, the classroom combined a positive supportive environment with the incentives afforded by academic progress. In addition to an increase in the sheer numbers of programs, the past 25 years have also seen the emergence of several strong conceptual or theoretical approaches to educating the emotionally disturbed. Out of these models have come a number of important precepts that have influenced the development of educational service programs. These include the concept of structure and the effec-

tiveness of direct behavioral intervention as well as a recognition of the importance of the student's family and the total ecology or environment.

The past 25 years of research and development have resulted in a large body of literature as well as the establishment of a separate, albeit not necessarily distinct, field within special education. For, despite the amount of work that has been done, special education for the emotionally disturbed has consistently been plagued with certain problems. Chief among these is the very definition of "emotional disturbance." Clearly apparent throughout the chapters in this monograph as well as in the professional literature is the uncertainty and outright confusion over what constitutes emotional disturbance and which students can be classified as such. This confusion is evident in the terms used to describe these students—terms such as "seriously emotionally disturbed," "behavior disordered," and "emotionally impaired." These definitional problems, with the attendant difficulties in identification, clearly seem to be the greatest impediment to full educational programming for these students. Recently, the defintional problems have been compounded by proposed changes in the regulations governing PL 94-142. If approved, these regulations will remove the exclusion of "socially maladjusted" from the federal definition of "Seriously Emotionally Disturbed." Initial reactions from program administrators has been concern over which students now will be eligible for service.

Despite the terminology and the concerns regarding eligibility, all professionals fully recognize that the needs of these students as well as the problems faced by the educational systems that must develop programs are real. In fact, the conceptualization of what was originally to be one monograph grew out of the concerns expressed by "grass roots" people—teachers and program administrators—who work with the emotionally disturbed. Their concerns, which were echoed in the professional literature, focused on two major areas. First and foremost were the problems of identification and assessment; assessment for deciding eligibility for services as well as for developing meaningful educational programs that address social and emotional needs as well as academics. Following assessment, the concerns centered on the organization of services, particularly in light of the diverse needs of the emotionally disturbed. Frequently mentioned were the problems of dealing, within a public school program, with disordered families and community disruptions.

To separate the emotional and social problems of emotionally disturbed children from their academic needs would be to ignore the basic tenet of their condition. While the classroom has been transformed to provide a benign learning environment, these children need to have the positive aspects of education extended throughout the special services available outside the classroom. A comprehensive system of management for intervention strategies, coupled with the establishment of partnerships with parents and service professionals, enables an order to permeate their experiences. Through the continuous coordination of extended educational services, these children can be influenced by an educational reality that

extends through all facets of their lives. The disparity between home life and educational instruction can be removed.

The complexity of issues was such that two volumes have been devoted to a discussion of the issues. Volume I provides an extensive discussion of the problems inherent in the definition and the companion problems of assessment. In addition, this volume also examines the issues related to developing and planning programs in the public schools. Volume II addresses the major areas related to service delivery, including both the organization and operation of public school programs, as well as considerations for alternative living arrangements. In addition, a chapter is devoted to presenting the personal experiences of several parents of emotionally disturbed children.

Together the two monographs present an overview of the complex problems involved in providing suitable educational facilities for emotionally disturbed children. Educators and service professionals are being called upon to make critical decisions. PL 94-142 has delegated an enormous responsibility to the public schools, straining their resources and questioning whether the present system of special services is adequate to the demands of a growing population of special students. School districts are confronting their own inadequacies and must realistically appraise their potential. The decisions concerning the effectiveness of special programs will be critical for the future of special education. If a change in services or curriculum is to be made, the time for instituting this change is the present. These volumes are designed as a guide to facilitate the process of self-appraisal. By providing a synthesis of existing programs, new educational technologies, and the legal ramifications of mainstreaming, we hope to establish a factual basis with which to approach intelligently the problems at hand.

M.M.N.
N.G.H.

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# Part 1: Identification and Assessment

# Social Policy Issues in Special Education and Related Services for Emotionally Disturbed Children and Youth

James M. Kauffman

With respect to special education for emotionally disturbed children, there is today one overarching social policy issue. The issue rests on the problem of definition, and it involves this question: Can the right of all disturbed children to special education be assured by government decree? My belief is that that right can not be guaranteed and that attempts to guarantee it are and will invariably be sham. My reasons for believing that the guarantee is necessarily sham are these: the definition of emotional disturbance is arbitrary; the current federal definition is very seriously flawed; the identification of disturbed children is subjective and somewhat unreliable even with the best definition one can construct; and the rights of handicapped persons present a set of policy problems that is essentially different from those presented by the rights of more objectively defineable minority groups whose distinguishing characteristics are irrelevant to their participation in social institutions. Current policy does not assure all disturbed children an appropriate education. The central issues involving definition, mandated services, and legal rights effectively preclude well-reasoned consideration of other policy questions, such as those regarding the nature of special education services, teacher training, and research. Answers to policy questions regarding services, training, and research are always hopelessly ambiguous when the definition of the population to be served is ambiguous and the children are unreliably identified.

## The Arbitrariness of Definition

Emotional disturbance presents a peculiar set of problems for policy makers because it is, probably to a greater extent than any other type of exceptionality, a figment of social convention. Perhaps because psychiatry has been extremely influential in the formation of public attitudes and social policy, creating an assumption that "disturbed emotions" and "mental illness" are disease entities, current social policy does not reflect the arbitrariness of the definition of emotional disturbance. Scull (1975) has described how the medical profession gained control over the designation and management of certain types of social deviance during the nineteenth century, eventually fixing in the public mind the notion that much troubling social behavior is attributable to physiological causes or arcane intrapsychic features and is treatable only by medical science. But it is abundantly clear that emotional disturbance is *not* a disease in any usual sense of the term—it is not a separate, distinct entity that invades a person or can be assessed reliably without reference to the environment in which a person lives. Rather, it is, as suggested elsewhere (Kauffman, 1979, 1981a; Kauffman & Kneedler, 1981), a phenomenon involving complex interactions among what a person does, how that person perceives and evaluates his or her own behavior and the environment, and how the environment responds. And it is the failure to come to grips with this central problem of definition or description of emotional disturbance that leads to the primary policy issues today.

Conceptual confusion and disagreement have always been rife among professionals who deal with disturbed children. The lack of consensus about what the problem of such children really is and what can or should be done about it has been highlighted by numerous writers and several major projects, including the Conceptual Project in Emotional Disturbance (Rhodes & Head, 1974; Rhodes & Tracy 1972a, b) and the Project on the Classification of Children (Hobbs, 1975a, b). Perhaps Rhodes and Paul have written the most succinct statement of the difficulty faced by scholars and policy makers:

> The epiphenomenal problem of deviance is complex and the definitions that exist are many. Each time a group of special children gain social and professional attention, a plethora of definitions of the problems of these children follow. The inconsistency is not, as is typically thought, simply in the definitions, but rather in the primary view of the world from which the definition is derived. (1978, p. 137)

The differences among the Weltanschauungs of various influential individuals and groups are reflected both in terminological chaos and in current social policy that is starkly unsuccessful in meeting the needs of most disturbed children. There is no standard terminology for the problems of disturbed children or even for the general category "Seriously Emotionally Disturbed." In fact, it is not uncommon to read or hear an extensive discourse on the differences between "emotional disturbance" and "behavior disorder" or between "emotional disturbance" and "social

maladjustment." Moreover, the rules and regulations related to PL 94-142 contain, in the definition of seriously emotionally disturbed, an attempted distinction between emotional disturbance and social maladjustment. Certainly children can and do exhibit social deviance in many different ways. Nevertheless, attempts to distinguish between groups designated by many of the common labels for social deviance, including socially maladjusted and seriously emotionally disturbed, are useless, or worse, in formulating social policy.

## Flaws in the Federal Definition

The problems of definition and terminology deserve close scrutiny because they are the beginning points for building a social policy. Current policy derives from a definition, with certain modifications, offered by Bower (1969). The definition of seriously emotionally disturbed included in federal rules reads as follows (with significant addenda to Bower's definition indicated by italics):

(i) The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree *which adversely affects educational performance:*

(A) An inability to learn which cannot be explained by intellectual, sensory, or health factors;

(B) An inability to build or maintain satisfactory relationships with peers and teachers;

(C) Inappropriate types of behavior or feelings under normal circumstances;

(D) A general pervasive mood of unhappiness or depression; or

(E) A tendency to develop physical symptoms or fears associated with personal or school problems.

(ii) *The term includes children who are schizophrenic or autistic. The term does not include children who are socially maladjusted, unless it is determined that they are seriously emotionally disturbed.* (*Federal Register*, 1977, p. 42,478)

Bower's definition is probably as useful as any that has been written to date. It lists five characteristics that are likely to result in a child's receiving a deviance label, and so it is useful in providing a general description of child behavior that is of concern to adults and that results in an educational handicap. But such description is not a sufficient basis for a social policy that mandates intervention for every disturbed child because it does not provide an unambiguous statement of who is and who is not disturbed. Consider, for example, the subjective interpretation that is required by some of the key terms and phrases in the definition: "to a marked extent," "over a long period of time," "satisfactory interpersonal relationships," "inappropriate," "pervasive," and "tendency."

The addenda to Bower's definition do not clarify anything. They are, in fact, redundant and obfuscatory. The addition of the clause "which adversely affects educational performance" is particularly puzzling. It is redundant with characteristics (A), "An inability to learn . . . ," if educational performance is considered to mean academic achievement. Furthermore, it seems extremely unlikely that a child could exhibit one or more of the characteristics listed to a marked degree and for a long time without adverse effects on academic progress. But what of the child who exhibits, let us say, characteristic (D), "A general pervasive mood of unhappiness or depression," and is academically advanced for his or her age and grade? If educational performance is interpreted to mean academic achievement, then the child would seem to be excluded from the category of seriously emotionally disturbed; if, on the other hand, educational performance is interpreted to include personal and social satisfaction in the school setting, then the clause is superfluous.

At the outset, then, the federal addendum to part (i) of the definition confuses the issue of the type of problem that should be the concern of special educators. But an even greater confusion is created by part (ii) regarding schizophrenia and autism[1] (i.e., childhood psychosis), and social maladjustment in relation to serious emotional disturbance. It is clearly inconceivable that a psychotic child would *not* be included under the definition; any such child will exhibit one or more of the five characteristics (especially B and/or C) to a marked degree and over a long period of time. Hence, the addendum is unnecessary. The last addendum regarding social maladjustment is logically impenetrable. A child could not be socially maladjusted by any credible interpretation of the term without exhibiting one or more of the five characteristics (especially B and/or C) to a marked degree and over a long period of time.

One is forced to conclude that the federal definition is, if not claptrap, at least dangerously close to nonsense. It is not surprising that social policy based on such a definition is problematic. Two questions, then, present themselves: 1) Could the definition be significantly improved? and 2) Would an improved definition resolve the social policy problems?

## Definition and the Problem of Identification

The definition could be improved considerably by omitting the addenda to Bower's characteristics. Removal of the addenda would eliminate the logical inconsistencies, terminological confusion, and redundancies, but

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[1]Federal rules and regulations have been changed. Autism has become a subcategory under "Other Health Impaired" rather than under "Serious Emotional Disturbance." Bower (1982) recently noted some of the policy problems presented by the exclusion of autism and social maladjustment.

it would not eliminate the most fundamental problem—the fact that emotional disturbance is whatever we choose to make it. This central problem is not unique to emotional disturbance. It is a fundamental and unresolvable problem in mental retardation, learning disabilities, and other conditions defined by social convention; and it is a more obvious problem in the case of milder forms of social deviance. The problem in mental retardation was described pungently by Blatt:

> The most recent, little appreciated but astonishing revision of the American Association on Mental Deficiency definition of mental retardation to include theoretical eligibility—i.e., psychometric retardation—to from one to two standard deviations on the "wrong" side of the mean literally revolutionized the incidence, prevalence, and concept of mental retardation, all with the simple stroke of Herbert Grossman's pen. We cannot redefine measles, or cancer, or pregnancy with so easy and such external procedures. The Grossman Committee, sitting around a conference table, reduced enormously the incidence of mental retardation, never having to "see," or "dose," or deal with a client, only having to say that, hereinafter, mental retardation is such and such, rather than this or that. What, then, is mental retardation?? (1975, p. 414)

The fact that emotional disturbance has no objective reality—like mental retardation, it is whatever we choose to make it—makes a social policy that mandates special services for all disturbed children and exacts penalties for noncompliance a tragic mockery. This would not necessarily be the case if there were highly reliable means of measuring the extent to which children meet an arbitrary behavioral standard—that is, the problem is not inherent only in the arbitrariness of the definition, but also in the difficulty in determining whether a given individual meets a standard set by the definition.

A definition can be arbitrary, yet serve social policy purposes well. For example, 18 years and older arbitrarily defines the population that is voting age today, and the former arbitrary standard of 21 years was negated. But there is seldom serious doubt about whether or not a given individual is a certain age. Were the determination of age an unreliable process or were a much less objective criterion (e.g., "social maturity") chosen as the standard for defining the voting population, then a different set of policies regarding voter registration and voting rights would be required. The definition of emotional disturbance cannot be reduced merely to a set of objectively observable behaviors; subjective judgment of how the child functions in a given environment is always required (Kauffman, 1981a). Hence, unreliability in identification can never be completely eliminated.

## Definition, Identification, and Rights

The Zeitgeist of the civil rights movement swept up the cause of the handicapped in the 1970s. Civil rights concerns led ultimately to the

propositions of Section 504 and PL 94-142, some of which now appear to be untenable. The civil rights movement fostered the notion that *any* minority, however defined, can be rationally and responsibly guaranteed its rights, however its rights are defined. Thus, today we have a policy guaranteeing the right to appropriate education ("appropriate" being very ill defined) for populations that are defined in practice primarily by the exigencies of the moment. Special education for seriously emotionally disturbed children is guaranteed under PL 94-142, not because the population is well defined, but rather because the rights movement could not tolerate the exclusion of any population of the handicapped, no matter how poorly defined or how undefinable and no matter how absurd the notion that an ill-defined group can be assured its peculiar rights by the coercive pressure of government.

The implementation of civil rights legislation is a complex and arduous task. In cases involving minorities or other groups whose definition and identification are relatively unambiguous and whose members seldom can pass as members of a different class (races and sexes, for example), civil rights can perhaps be effectively guaranteed by law. A new and complex dimension is added to the problem of civil rights implementation, however, when the very identification of an individual as a member of a special population or class (i.e., in "legalese," a "suspect class" deserving special protection of the law) is arguable. Judgments about a child's behavior that lead to his identification as seriously emotionally disturbed are, unlike those defining race and sex, necessarily both arbitrary and subjective. Not only must one consider the accuracy of an individual's identification, but also the consequences of such identification. Identification of the child as disturbed bestows certain rights upon him (e.g., the right to an IEP, to due process hearings, to education in the least restrictive environment), whereas failure to identify him affords no special protection of the law (the assumption being that if he is not a handicapped child, then his rights are already sufficiently protected by laws governing the education of nonhandicapped children). The intent of Section 504 and PL 94-142 may have been to guarantee the rights of all seriously emotionally disturbed and other handicapped children to special education. But it will be particularly difficult, if not impossible, to fulfill that guarantee for emotionally disturbed children because their identification is subjective and can be avoided by school officials when it is in their own best interests to do so.

## Effects of Current Policy and a Possible Policy Change

Given that handicapped children must be identified in order to receive special protection of the law and appropriate education and related services, but also that identification is a subjective and unreliable process, what is the result of a policy that not only requires identification of all

disturbed children but demands as well that all identified children be served? The result is a disastrous hypocrisy. It cannot be otherwise. One must consider that current policy emphasizes punishment for noncompliance, not reward for approximations of full compliance. To require school officials to be perfectly candid about the number of emotionally disturbed children in their schools is to require their self-incrimination. Consider the facts that have been presented more extensively in other sources (see Grosenick & Huntze, 1979; Kauffman, 1980, 1981a; Magliocca & Stephens, 1980). First, prevalence studies indicate that 2% is an extremely conservative estimate of the percentage of school age children and youth who are reasonably considered to be emotionally disturbed, yet only about one-third of that percentage (i.e., about 0.7%) are being served by special education—in spite of the fact that the law says that every handicapped child must be served. [2] A conservative estimate of the additional cost of serving 2% of the school age population as emotionally disturbed is $2.3 billion per year, not more than 40% of which would be provided by the federal government. Even if the funds were made available in 1982, school officials could not find adequate personnel to staff the programs—the trained personnel do not exist and cannot be quickly obtained at any price.

In short, current policy has not resulted in services for anywhere near the number of disturbed children we have good reason to believe need special intervention. Our present policy does not take into consideration the arbitrary nature of the definition of emotional disturbance. It ignores the fact that most disturbed children can be classified as disturbed or normal for administrative convenience or out of necessity. It is blind to the fact that there are neither resources of money nor of trained personnel to serve all children who could reasonably be identified as disturbed. And it relies almost totally on coercion, on threatened negative consequences, to obtain a semblance of compliance with the law, a contingency system certain to foster avoidance or denial. It forces school officials to close their eyes to the needs of children if they haven't the resources to serve them, because to recognize the need without providing the appropriate service is to risk losing everything in the way of federal support. The policy is analogous to telling the destitute parents of a large family of hungry children who are receiving grants of food that they must feed all their children well, for if it is found that one of the children is hungry and not being fed, then all the food grants will be withheld. Under such circumstances, what would rational parents do if they had a hungry child and no more food? Probably they would vehemently deny their child's hunger to any inquirer. It is tragic that our current social policy regarding education of the handicapped is not more humane and consistent with principles of positive behavior management.

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[2] A report of the U. S. General Accounting Office published in September 1981, *Disparities Still Exist in Who Gets Special Education*, indicated that special education services for the majority of emotionally disturbed children are inadequate or nonexistent.

Social policy could be changed to support the growth of services for the emotionally disturbed (and services for other categories of mildly handicapped as well). Such a policy change should involve removal of the requirement of service for every child who has been identified as handicapped. Threats of withdrawal of funds or of other sanctions would be reserved for those cases in which there was an obvious lack of good faith effort to identify and serve disturbed children. Incentives for serving identified children would be provided. Such a policy would not guarantee service to all handicapped children. But as we have seen, such a policy change would be no great loss because the guarantee of appropriate service for every disturbed child is by necessity a sham. A more realistic and positive approach is to set goals and reward approximations of achieving them.

## Policies On Intervention, Training, and Research

All indications are that the majority of emotionally disturbed children are not being served by special education (Kauffman, 1980, 1981a, b). Most of them remain in regular classes with regular teachers who have no special training in how to deal with persistently disordered behavior. Under these circumstances it may seem necessary to formulate policies regarding intervention strategies, personnel preparation, and research. But until the more fundamental issues of definition and mandated services are resolved, other issues are academic. Here, too, one faces a great dilemma: Lack of a clear policy may have negative effects, but even a well-intentioned policy also can have very undesirable outcomes. Social policy, as embodied in the law and judicial process and behavioral science appear to have the common goal of enhancing the social order, but they often come into conflict in practice; and legal victories ostensibly based on scientific evidence can have adverse effects on the very individuals they were designed to benefit (Baumeister, 1981; Townsend & Mattson, 1981). Thus, good intentions on the part of policy makers and behavioral scientists do not guarantee an ultimate outcome that is beneficial.

Townsend and Mattson (1981) have suggested that in the development of policy regarding the rights of the handicapped one must consider several interconnected sources of information and opinion: public attitudes, personal satisfaction, science and technology, laws and judicial interpretations, and political coalitions. To the extent that any one of these sources and its relationships to the others are ignored, social policy is likely to be unsuccessful. In the area of emotional disturbance as well as in special education in general, we have not fully considered the complexity of the problems we face in formulating policy that will be maximally beneficial. Instead, we have rushed headlong into policies that are well intentioned but cannot work because they fail to account for the realities of others' perceptions, needs, and capabilities. To make recommendations here regarding what policy we should formulate for intervention strategies, per-

sonnel preparation, and research would be foolhardy. But it is safe to say that in formulating such policy it would be prudent to think more carefully than we have in the past about the interests, perceptions, and likely reactions of people outside our professional enclave.

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# Assessment of Behavior Disorders in the School Setting: Issues, Problems, and Strategies

Hill M. Walker

Issues in assessment of mild behavior disorders in the school setting are myriad, complex, and increasingly controversial. It is no easy task to develop a rationale for the inclusion or exclusion of specific issues on this topic. The author used a combination of the following criteria to select general content areas and specific issues within them. The areas and issues selected 1) have direct implications for the assessment of behavior disorders in the *school setting*; 2) possess some degree of professional salience within the educational or psychological literatures; 3) influence, constrain, and/or mediate actual assessment practice, and 4) are controversial in that there seems to be divergent professional opinion regarding their definition and/or resolution.

This paper will discuss issues, problems, and strategies within two major areas (e.g., *conceptual* and *procedural*) relating to the assessment of mild behavior disorders in children. The content of the paper will not be treated in an unbiased or objective fashion. The author will advocate for specific positions, points of view, and actual practice that, in his opinion, have the potential to positively influence current practices in the assessment of mild behavior disorders. It is not expected that the material in this paper will contribute directly to enduring professional consensus on the issues presented. Nor will clear-cut solutions be provided to the complex problems of definition, classification measurement practice that have plagued the field of behavior disorders for so long. Rather, a major goal of this paper is to examine and call into question many of the as-

sumptions that have guided our practices in relation to the measurement of child behavior disorders in the school setting and that determine the type and quality of services eventually delivered to such children. In the author's view, many of these assumptions prevent us from developing bases for change in our assessment practices which will more functionally serve the needs of behavior disordered children in the school setting. Before turning to a discussion of specific issues, it seems appropriate to examine the current state of assessment and service delivery practices for behavior disordered children and to speculate upon why such a dilemma exists in this general area.

## Current State of Assessment and Service Delivery Practices

There seems to be general agreement in the educational community that available eligibility criteria and assessment procedures are not adequate to the tasks of reliably separating behavior disordered from non-behavior-disordered children and deciding which identified children are in need of existing services. It is apparent that the field of behavior disorders has been and continues to be at a severe programmatic disadvantage. This is due to an inability to reach a professional consensus regarding a definition of its subject matter and legitimate qualifications of individuals for services. Technologies exist to screen, identify, measure, and remediate the broad range of behavior disorders encountered in the school setting. However, because of competing models of human behavior, psychological assessment, and therapy, and a reliance upon medically based, clinically oriented definitional and classification systems that often have only limited applicability to the school setting, the field has exhibited a kind of paralysis and ambivalence regarding its legitimate domains of activity. Children in general, and especially behavior disordered children, have not been well served by this dilemma. The real tragedy of our professional immobility is that many children with legitimate behavior disorders are frequently denied access to services that could significantly affect their educational adjustment and social development because they do not fit vaguely defined eligibility criteria and categories of emotional/behavioral disability.

What is an emotionally disturbed or behavior disordered child? The answer depends (among other things) upon who is asked, and his or her particular philosophical orientation regarding human behavior and psychopathology. Unfortunately, professionals have been unable to agree on a precise use of terms such as emotional disturbance and behavior disorders (Balow, 1979). For reasons relating to matters of substance and philosophy as well as clarity, the term "behavior disorders" will be used whenever possible in the remainder of this paper to refer to the full range of disorders, problems, and disturbances of child behavior commonly encountered in the school setting.

The school system has had, and continues to have, great difficulty in deciding its proper role in relation to child behavior disorders. This problem has been compounded by definitional vagueness, conflicting support service demands from teachers and other school professionals, and territorial imperatives relating to professional legitimacy and competence. There is, however, an increasing trend for school systems to provide for the full range of needs and service demands of this population of children. This is probably a function of at least three developments: 1) the passage of PL 94-142, 2) an improving technology for delivery of high quality therapeutic services in the school setting, and 3) the publication of efficacy studies of non-school-based mental health services for children which tend to show weak effects on child behavior in the school setting (Achenbach, 1974; Levitt, 1971; Sheperd, Oppenheim, & Mitchell, 1971).

Schools have also experienced great difficulty in distinguishing discipline problems from behavior disorders and subsequently in deciding how to deal with them in a programmatic sense. At present we do not have the classification taxonomies or measurement strategies that will allow us to make these discriminations with precision and reliability. If a child is perceived as a discipline problem, he or she is likely to be exposed to a punishment or control strategy. In contrast, if the same child is perceived as having a behavior disorder or as being emotionally disturbed, a therapeutic regimen of some type is the most likely response to the problem (Neel & Rutherford, 1981). It is apparent that definitional criteria and assessment procedures play a powerful role in determining a school system's response to dysfunctional child behavior, with equally powerful implications for the children involved.

Another factor that could account for our imprecision in assessing and remediating behavior disorders in the school setting is the failure to distinguish between dysfunctional child behavior in school and nonschool settings. Traditionally, schools have adopted a medically based, clinical perspective in the definition, assessment, diagnosis, and treatment of behavior disorders in children. Dysfunctional or pathological behavior is seen as specific to, and originating within, the child. Behavioral and emotional difficulties are viewed as stable phenomena that are relatively invariant across settings (Ullmann & Krasner, 1965). The most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual (1980), however, does acknowledge that symptoms of such phenomena in childhood disorders are differentially displayed across settings.

Advocates of this viewpoint have suggested that a diagnosis of behavioral/emotional difficulty in one specific setting (e.g., school) has no validity unless manifestations of it are also observed in a variety of other settings (e.g., home, community, clinician's office). Rarely are such disorders considered setting specific when viewed from either a "states and traits" model of personality (Allport, 1966, 1974), or from a medical "disease" model of psychopathology (Ullmann & Krasner, 1965, 1969). In-

creasing evidence, however, is suggesting that both pathological and nonpathological forms of behavior, are, to a large extent, situation specific (Johnson, Boldstad, & Lobitz, 1976; Mischel, 1968, 1969; Wahler, 1969; Walker, Hops, & Johnson, 1975). Given that such is the case, there are at least four possibilities relating to the interaction between setting and the actual presence or absence of disordered child behavior. That is, children can be disordered at school only, in nonschool settings only, in both school and nonschool settings, and in neither. Schools and the behavior disordered children they serve could potentially benefit greatly from the development of definitional, classification, and assessment models whose content is focused on child behavior in the school setting, as opposed to continued reliance on generic, setting-nonspecific systems whose content is frequently determined by a mixture of parent, teacher, and clinician's ratings. Such a system could facilitate decision making relating to identification, service delivery, and remediation within the school setting, as well as referral of children to clinical facilities and resources external to the school setting. In the author's opinion, the factors discussed above account for many of our problems in serving behavior disordered children in school settings. Further, these factors are largely contextual in nature. That is, they are a function of attitudes, assumptions, expectations, and beliefs (relating to human behavior and its causes) that we have been taught to view as valid, true, and appropriate. In the author's view, these contextual variables are at the core of our problems in serving behavior disordered children because they influence the kinds of assessment, classification, and service delivery decisions we make as professionals. Unfortunately, variables of this type often control the assessment process in ways that do not serve the best interest of behavior disordered children who are in need of direct services. A fuller explication of these variables and their programmatic implications will be presented in the sections that follow.

## Conceptual Issues

Divergent conceptualizations of human behavior, the etiology of emotional/behavioral disorders, and classification systems have had a powerful influence upon the *assessment* of behavior disorders in the school setting. The types of assessment procedures chosen (projective tests, teacher or parent ratings, behavioral role play tests, interviews, or direct observations in the natural setting), the setting(s) in which assessments are made (school versus home, natural setting versus clinician's office), and the interpretation of the results, are all directly influenced by such conceptualizations. At present, there appears to be little hope of a professional consensus regarding such conceptualizations and with it, standardization of practice and decision making. The only consensus seems to be that everyone is dissatisfied with the traditional efforts at defining, classifying, and identifying emotional/behavioral disorders in children (Wood & Lakin, 1979).

Some major conceptual issues that impinge upon the assessment of school behavior disorders are: 1) the continued use of vague constructs such as *emotional disturbance* to refer to disordered child behavior; 2) reliance upon conceptualizations of disordered child behavior in school which are not specific to that setting; 3) the influence of models of personality upon conceptualizations of child behavior; 4) the influence of classification systems upon conceptualizations of disordered behavior in the school setting; 5) the influence of setting and behavioral expectations upon child behavior; 6) the role of social agents' tolerance levels in defining disordered child behavior; and 7) criteria for determining disordered behavior in the school setting. These issues and their implications for the assessment process will be discussed further.

## Emotional Disturbance Versus Behavior Disorders

The school system's adoption of the term emotional disturbance to describe children who experience disorders of *behavioral* functioning is unfortunate. Use of the term focuses the attention of educators upon emotional antecedents to disordered behavioral functioning and leads to a search for child-specific etiological factors, via the assessment process, to account for the behavioral problems in question. In those cases in which such causal agents are thought to be identified via assessment procedures or clinical judgment, their programmatic implications for educators are often extremely limited and sometimes absolve them of any responsibilities for remediation.

We would do well to restrict our assessment efforts to overt, observable dimensions of child behavior and to assess it within those settings where it is perceived to be disordered. A measurement strategy of this type focuses our attention upon the child's learning history, competence or skill level, situational demands and expectations, and environmental contingencies as possible causal agents. A number of investigators have urged that conceptualizations of disordered child behavior be based upon direct observation of overt behavior rather than clinical inference (Clarizio & McCoy, 1976; Freemont & Wallbrown, 1979; Quay, 1972; Ross, 1971; Walker, 1979).

Unless criteria can be developed which will reliably distinguish emotionally disturbed from behavior disordered children, the author recommends that we discontinue use of the term emotional disturbance. Further, the term behavior disorders should be reserved for describing disordered child behavior that can be observed and assessed reliably in those settings where it is judged to be a problem.

## School Versus Nonschool Conceptualizations of Child Behavior

Traditional conceptualizations of child behavior disorders are rarely set-

ting specific, perhaps because behavior disorders are thought not to be setting specific. School systems have relied upon conceptualizations of disordered child behavior supplied by the medical and clinical professions which are generic in nature and do not take performance within specific settings into account. The relevance of substantial portions of these conceptualization systems for school-related behavior disorders is obscure. Until recently, however, educators have rarely questioned their utility or content.

It can be argued, for example, that stimulus conditions, performance demands and behavioral expectations, and social relationships are radically different in the school and home setting. Disordered child behavior in these two settings may be quite different in both form and content. In those cases in which a child's behavior pattern is disordered in both the school and home settings, there is no guarantee that specific behavior problems will be identical in the two settings or that they are a function of the same causal factors. Separate conceptualizations are needed for child behavior in the school setting. The specific content of each conceptualization should be determined by direct measures of child behavior within the setting, by information on the characteristics and performance demands of the setting, and by the perceptions of key social agents (teachers versus parents) within the setting regarding child behavior in that setting.

In the author's view, a school-based conceptualization should focus equally upon educational and social development. Child behavior problems should be identified which can compete with development in each of these major areas and measurement strategies should be developed which can assess their occurrence in natural settings. Such strategies would include, at a minimum, teacher ratings of child behavior and direct observations recorded in the appropriate setting(s).

## The Influence of Models of Personality Upon Conceptualizations of Child Behavior

There are numerous theories of personality which purport to account for both normal and abnormal behavior. Conceptualizations of psychopathology and psychotherapy have traditionally developed from theories of personality (Hyman, Bilus, Dennehy, Feldman, Flanagan, Lovoratano, Maital, & McDowell, 1979). Ultimately such theories have a powerful influence upon one's view of child behavior disorders, for example, how they are defined, acquired, measured, and remediated. Rarely are such theories either experientially or empirically based. Further, they describe personality development processes in broad, generic terms, with the home setting viewed as having the greatest influence in the social and personal development of the child.

Many explanations have been promulgated to account for the instructional process, and impressive efforts have been mounted to develop a unified theory of instruction (Bruner, 1968). In the area of child behavior

and social development in the school setting, however, we have relied upon psychology and psychiatry to provide explanations for us via personality theory. Hyman et al. (1979) describe five models of personality which have most influenced educators' conceptualizations of disordered behavior in the school setting. These are: 1) psychodynamic-interpersonal, 2) behavioral, 3) sociological, 4) eclectic- ecological, and 5) humanistic.

These theories provide "windows on the world" for school professionals serving children with behavior disorders. The same behavioral phenomena can be described, analyzed, and interpreted using each of these different models, and it is likely that radically different explanations of the problem will be offered by professionals subscribing to each theory. In some respects these theories have done more harm than good in terms of our efforts to develop effective interventions and services for behavior disordered children in the school setting. Some of their more deleterious functional effects have been to: 1) focus our attention on alleged causal variables that are either specific to the child or external to the school setting; 2) cause us to seek explanations of disordered child behavior within the realm of intrapsychic, nonobservable phenomena, rather than to analyze child performance within the context in which it is judged to be problematic; 3) cause us to give up on problem amelioration as a function of the discovery of causal variables that are viewed as too deeply imbedded in the personality to be responsive to change procedures; 4) influence us, as educators, to apply indirect methods of treatment (e.g., verbal psychotherapies) to produce changes in overt behavior patterns (aggression, social withdrawal, conduct problems); 5) provide support and encouragement for the continued use of projective assessment methods with behavior disordered children as a vehicle for explaining why the behavior problem exists and for deciding upon appropriate therapies (the validity of these methods for both purposes is extremely limited); and 6) influence us to view problematic child behavior in terms of trait labels (e.g., devious, manipulative, aggressive, obsessive) which suggest stable manifestations of the trait label or attribute across settings and time.

School systems are in need of a theory of child behavior and school psychopathology which is both experientially and empirically based. It should focus on overt, observable child behavior in the school setting, that is, on what children say and do, not what they think and feel. The content of this theory should be generated by such variables as: 1) the interactions that occur between children and school social agents (peers and teachers); 2) the characteristics of the school setting and opportunities it provides for social and educational development; 3) the performance demands and behavioral expectations of school personnel; 4) the tolerance levels of classroom teachers in defining and labeling deviance; 5) the role of the home and school settings in either producing and/or maintaining disordered child behavior; 6) constraints of the school system in serving behavior disordered children; 7) effective therapies and interventions for different types of behavior disorders common to the school setting, and 8) taxonomies and classification systems that describe

*school-related* behavior disorders. If such a theory were developed, we would be in a far better position to deliver cohesive, relevant, and cost-effective services to behavior disordered children which would have some likelihood of directly affecting their social and educational development in the school setting.

## The Influence of Classification Systems Upon Conceptualization of Child Behavior in School

Classification systems for describing psychopathology and disordered functioning abound in the clinical literature. In 1966, the Committee on Child Psychiatry of the Group for the Advancement of Psychiatry noted that at least 24 different systems had been proposed for classifying the behavior disorders of childhood (Freemont & Wallbrown, 1979). The most current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) (1980) devotes an entire section to the disorders of infancy, childhood, and adolescence. Clearly our problem is not, and has not been, a lack of available systems for classifying child behavior disorders. Rather, our classification problems have been in the areas of 1) relevance of content to the school situation; 2) diagnostic precision based on the criteria contained in such systems; 3) ability of such systems to identify homogeneous groupings of children with specific behavior disorders who may or may not share common etiologies; 4) use of such systems as a basis for comparing different interventions for the same behavior disorder, and 5) ability of such systems to prescribe measurement strategies, other than clinical judgment, for assessing child status on specific disorders.

Traditional classification systems have generally failed in each of the aforementioned areas. Other criticisms that have been leveled at them include lack of specificity, failure to include developmental perspectives, failure to distinguish child from adult disorders, failure to specify sex-related and age-related behavior disorders, and failure to be consistent in classification criteria (Achenbach, 1978, 1979; Achenbach & Edelbrock, 1978; Freemont & Wallbrown, 1979; Reichler & Schopler, 1976).

Reichler and Schopler (1976) suggest that classification should provide a basis for prevention, prescription, and prognosis, the three functions of diagnosis. No classification or diagnostic system currently available provides for these functions in relation to childhood behavior disorders in the school setting. This goal is not likely to be attained until systems are developed which are based upon the ratings or judgments of key social agents in the school setting (teachers, psychologists, peers, professionally trained observers) in relation to behavioral descriptions of what children say and do in that setting.

The primary content sources for the development of traditional classification systems have been the clinical judgment(s) of mental health professionals, cataloguing of presenting symptoms of children seen in child

guidance clinics and other mental health settings, and parent and teacher ratings. Parent and teacher ratings have been sampled to a substantially lesser degree in traditional systems than have clinical judgment and cataloguing of symptoms.

The 1980 DSM classification system is perhaps most representative of the types of childhood disorders identified when clinical judgment is the primary content source. The system contains five major groupings distinguished from each other by predominant area of disturbance. These are presented in Table 1.

Table 1
(1980) DSM Childhood Disorders

1. Intellectual
   —Mental Retardation
2. Behavior (Overt)
   —Attention Deficit Disorder
   —Conduct Disorder
3. Emotional
   —Anxiety Disorders of Childhood or Adolescence
   —Other Disorders of Infancy, Childhood, or Adolescence
4. Physical
   —Eating Disorders
   —Stereotyped Movement Disorders
   —Other Disorders with Physical Manifestations
5. Developmental
   —Pervasive Developmental Disorders
   —Specific Developmental Disorders

*Note*: From *Diagnostic and statistical manual of mental disorders* (3rd ed.) by the American Psychiatric Association, 1980. Copyright 1980 by American Psychiatric Association. Reprinted by permission.

With the exception of the categories under Behavioral (Overt), the disorders represented by these major groupings have only limited reference to the kinds of behavior disorders and adjustment problems children exhibit at school and which disrupt educational or social development, yet this system is used extensively by school professionals in diagnosing and classifying child behavior disorders in the school setting. The author is not denying the generalized validity of these disorders—just their relevance for the task of identifying and prescribing for behavior disorders at school.

Numerous studies in the published literature have reported attempts to develop empirically based classification systems for child behavior disorders (Becker & Krug, 1964; Kulik, Stein, & Sarbin, 1968; Patterson, 1964; Phillips, 1968; Quay, 1964, 1972; Ross, Lacey, & Parton, 1965; Walker, 1970). As a rule, these studies have factor-analyzed ratings of child behavior by teachers, parents, and clinicians in an attempt to isolate homo-

geneous behavioral groupings for diagnostic and treatment prescription purposes. The number of factors identified in these studies has varied from two to as many as thirteen (Peterson, 1965; Spivack & Swift, 1966). Systems of this type generally have much greater relevance for school-rated behavior disorders than the more traditional models based largely upon clinical judgment. There appears to be substantial commonality among the factors reported in these studies.

Few studies have been reported in which standardized intervention procedures have been developed explicitly for use with homogenous groupings of children representative of factor-analytically derived behavior disorders. The work of the author and his colleagues at the Center at Oregon for Research in the Behavior Education of the Handicapped (CORBEH) (1971-79) is a case in point (Walker, 1977; Walker, Hops, & Greenwood, 1976; Walker & Hops, 1979). Over an eight-year period, they developed, tested, and validated four comprehensive behavior management packages for use with commonly encountered school behavior disorders. Each package contains specific identification criteria and measurement instruments/procedures for use in screening, assessment, and program evaluation. These packages are designed respectively for use with acting out, low academic survival skill, socially withdrawn, and socially aggressive children. More work of this type needs to be conducted so that an array of standardized intervention procedures/programs will be available to school professionals in providing for the needs of behavior disordered children.

In the last few years, some positive and potentially very useful work has occurred in the area of developing empirically based classification systems that are increasingly applicable to school-related behavior disorders (Achenbach, 1978, 1979; Achenbach & Edelbrock, 1978; Freemont & Wallbrown, 1979; Ross, 1980; Schaefer, in press). This work has been geared toward specific school behavior problems in some instances (Freemont & Wallbrown, 1979). Other investigators have distinguished behavioral content, rating instruments, and empirically derived clusters for school versus home settings (Edelbrock, 1979). Further, Achenbach and Edelbrock (1978) and Edelbrock (1979) have identified behavioral clusters and classification systems that are specific to sex and age levels. This work recognizes that the content of specific behavior disorders is often quite different for males and females and that the behavior problems children experience show some change across age levels.

Freemont and Wallbrown (1979) review different systems for categorizing learning and behavioral problems from the standpoint of whether they involve behavioral content that can be observed in the classroom or depend upon psychological constructs inferred by mental health specialists. The authors suggest a school-specific classification system for use in diagnosis, assessment, and treatment prescription that consists of seven behavior patterns. Quay's (1972) system of four behavioral clusters is subsumed by Freemont and Wallbrown because they view them as representative of stable behavior patterns that are observable and that can be rated

reliably in the classroom. The seven patterns are: 1) personality problems, 2) conduct problems, 3) immature, inadequate behavior, 4) socialized delinquency, 5) severe emotional disturbances, 6) social misperception, and 7) learning disabilities. The latter three categories were included to provide coverage of major areas of problematic functioning not addressed by the Quay system. The positive features of this work are that the authors have attempted to produce a classification system based upon *observable* classroom behavior that is specific to the school setting.

Several investigators have argued for the validity of bipolar classifications of disordered child behavior (Achenbach & Edelbrock, 1978; Edelbrock, 1979; Ross, 1980; Schaefer, in press). Ross (1980), in reviewing the available evidence and work on classification of child psychopathology, suggests that a strong case can be made for reducing existing behavioral clusters, factors, or patterns to a bipolar dimension that characterizes the *direction* of disordered behavior, that is, either toward or away from the environment. This dimension has been variously conceptualized as 1) excessive approach behavior (aggression) versus excessive avoidance behavior (withdrawal), 2) conduct problems versus personality problems, and 3) internalizing (problems with self) versus externalizing (problems with the environment). Achenbach and Edelbrock (1978) and Edelbrock (1979) note that in spite of the diversity of rating instruments, raters, settings, and studies reported in the literature, there is strong evidence for the existence of such a bipolar conceptualization of child behavior disorders. This bipolar conceptualization has a great deal of relevance for the treatment of school-based child behavior disorders.

Ross (1980) suggests that behavior which our society defines as disordered or problematic falls into two major classes, depending on whether the behavior deviates from the norm by occurring too *rarely* or too *frequently*. For example, behavior disordered children are usually either deficient in appropriate adaptive skills and competencies that contribute to satisfactory educational and social development and/or they engage excessively in maladaptive, inappropriate behavior that competes with such development and is outside the referring agent's range of tolerance. On the one hand, we are dealing with insufficient levels of behavior which call for an acceleration intervention to build in the desired skills, competencies, or behavioral responses. In contrast, excessive levels of maladaptive behavior usually require a deceleration procedure designed to reduce or eliminate specific pinpoints. The CORBEH behavior management packages referred to previously are divided equally into this dichotomy. For example, the Program for Academic Survival Skills (PASS) and Procedures for Establishing Effective Relationship Skills (PEERS) programs are concerned respectively with building academic survival skills and adaptive social skills among populations of school children deficient in them. In contrast, the (CLASS) Contingencies for Learning Academic and Social Skills and (RECESS) Reprogramming Environmental Contingencies for Effective Social Skills programs focus respectively upon the reduction of acting out and aggressive behavior to within normal limits

among children who are outside the normal range on these behavior patterns.

Assessment methodologies geared toward children with mild behavior disorders would benefit from adoption of this simple bipolar classification system. Such methodologies would be tied directly to treatment prescription processes and the selection of appropriate services for remediation of specific disorders and behavior patterns. It would also be possible to establish normative levels of performance or behavior patterns representative of this dichotomy for use in both screening and treatment evaluation tasks (Walker & Hops, 1976). Finally, summative measures of performance such as sociometric status and achievement level could be used as validation criteria for selecting intervention target skills and competencies, that would have a maximum impact upon child development and school adjustment (Foster & Ritchey, 1979).

## The Influence of Setting and Behavioral Expectations Upon Child Behavior

Observers of child behavior across a variety of settings are continually impressed with how different child behavior can be in terms of content, level, topography, and form from setting to setting. Mischel (1968, 1969) has provided an eloquent conceptualization of the situational specificity of human behavior. This specificity doubtless reflects strong differences between settings (e.g., home versus school, classroom to classroom, playground versus classroom) on such variables as 1) the stimulus conditions, setting events, and behavioral contingencies that exist within them; 2) the behavioral/performance expectations of social agents in the setting; and 3) the tolerance levels of such agents for problematic, maladaptive, or disordered child behavior. The extent to which each of these variables contributes to the definition and labeling of child behavior as problematic is presently not known. It is well established, however, that children who are labeled as mildly behavior disordered by one teacher are not so perceived by all teachers to whom they are exposed. The more extreme the behavior disorder, the more likely it is that such consistency in labeling will be observed. In the author's opinion, the teacher's behavioral expectations play a major role in this process and subsequently affect teacher-child interactions in a direct manner.

The work of Brophy and Good (1970, 1974), for example, provides compelling evidence that classroom teachers not only hold differential performance expectations for children in their classes, but that they communicate them behaviorally. In their sample, teachers demanded better performance from those children for whom they had higher expectations, and were more likely to praise such performance when it was elicited. In contrast, they were more likely to accept poor performance from students for whom they held low expectations, and were less likely to praise good performance from those students when it occurred. It is conceivable that teachers hold equally well-developed standards and expectations for

adaptive and maladaptive types of child social behavior with clearly differentiated treatment of children whose behavior patterns fall within and outside them.

The author is currently engaged in research on the mainstreaming process (Walker, 1979) which systematically takes the receiving teacher's social behavior standards and expectations into account in the placement and integration process. The author has developed and begun the validation and standardization of two instruments for use in measuring this variable. The first instrument requires the teacher to make rating judgments in relation to 56 descriptions of adaptive skills and competencies that contribute to success in the classroom and 51 descriptions of maladaptive behavioral pinpoints that disrupt or interfere with satisfactory classroom adjustment. A second instrument contains correlates of child handicapping conditions that may cause resistance to the placement/integration process. These instruments have generalized applicability to the task of assessing teacher expectancy effects in relation to mild behavior disorders in the school setting. Whenever possible, the teacher's expectations should be assessed in the process of evaluating child behavior in any given setting for the purpose of determining whether it is disordered. The author has found tremendous variability among samples of both regular and special education teachers in terms of their social behavior standards and expectations. Such variability has powerful implications for the screening, placement, and treatment of behavior disorders in the school setting.

## The Role of Social Agents' Tolerance Levels in Defining Disordered Child Behavior

Although behavioral expectations and standards obviously play an important role in the assessment of problematic child behavior on a case-by-case basis, the tolerance levels of classroom teachers may play an even more direct role in this process. Ullman and Krasner (1969) and Ross (1980) have all emphasized the important role that the tolerance levels of social agents play in defining child behavior as abnormal or disordered. In fact, Ullman and Krasner (1969) note:

> Behavior which is called abnormal must be studied as the interaction of three variables: the behavior itself, its social context, and an observer who is in a position of power. No specific behavior is abnormal in itself. Rather, an individual may do something (e.g., verbalize hallucinations, hit a person, collect rolls of toilet paper, refuse to eat, stutter, stare into space, or dress sloppily) under a set of circumstances (e.g., during a school class, while working at his desk, during a church service) which upsets, annoys, angers, or strongly disturbs somebody (e.g., employer, teacher, parent, or the individual himself) sufficiently that some action results (e.g., a policeman is called, seeing a psychiatrist is recommended, commitment proceedings are started) so that the society's professional labelers (e.g., physicians, psychiatrists, psychologists, judges, social workers) come into contact with the individual and determine which of the current sets of labels (e.g., schizophrenic reaction, sociopathic personality, anxiety reaction) is most appropriate. (p. 21)

Except for the examples, settings, and agents used by the authors, they may as well have been discussing behavior problems and disorders of children in the school setting.

Behavior disorders cannot be judged in isolation. The context in which the problematic behavior occurs and social agents' judgments of it must be taken into account systematically in the evaluation process. Ross (1980) notes that tolerance levels of social agents in natural settings (parents, teachers) may have to change in certain instances—otherwise a child is asked to adjust to an intolerable situation.

It is likely that classroom teachers' tolerance levels would show the same degree of variability as do their expectations of child performance and social behavior. Teachers likely also show differences among themselves in terms of their tolerance for types of child behavior and the age at which certain child behaviors are exhibited. Studies of the referral process show that teachers are much more likely to refer hyperactive, aggressive, disruptive children than they are withdrawn, phobic, or depressed children. Doubtless, one reason for this is that teachers are generally much less tolerant of disruptive, acting out forms of child behavior—perhaps because disorders of this type place severe pressures upon the management and instructional skills of most teachers. What does this mean in a practical sense? It means that many children with nondisruptive behavior disorders are much less likely to be referred and placed in contact with needed services. It probably also means that many children with minimal repertoires of acting out or disruptive behavior are referred and labeled who should not be. Therefore, we should not rely exclusively upon teacher referral processes to define children who are in need of behavioral services. Screening procedures have been developed which require each child to be evaluated by teachers on a regular basis for specific learning or behavioral problems (Greenwood, Walker, Todd, & Hops, 1979a; Kirschenbaum, Marsh, & Devage, 1977). Additional work needs to be done in this area to develop cost-effective, mass screening methods that take advantage of the power and sensitivity of teacher judgment in identifying learning and behavior problems.

Increasing calls have been made for educators to distinguish between disturbed child behavior and behavior that is disturbing (Tewksberry, Note 1). This notion has considerable face validity. However, if Ullmann and Krasner (1969) and Ross (1980) are correct in their conceptualizations of child behavior, the perceptions of social agents in the child's environment (parents, teachers) are an integral part of the process used to define behavior as problematic or disordered. If this is true, then it really may not be possible to make such a distinction reliably. Further, we may not want to. If a given child's behavior is viewed by a teacher as problematic and disturbing, is that child at any less risk than one whose behavior is viewed as disordered but not disturbing? One could make a convincing argument that the educational adjustment and/or social development of both children may be equally impaired.

The response of educators should be identical in both situations. That is, careful assessments should be made of the child's behavior, the social context in which the problems exist and the teacher's tolerance level and expectations in order to determine appropriate alternatives. In many instances, both child behavior and teacher expectations may have to change to resolve the problem—in other cases, only behavior or teacher expectations. There are massive logistical barriers involved in changing teacher expectations or tolerance levels. There will be many instances in which the only alternatives will be either to change the child's behavior to meet teacher standards or to change placements. Unless we adopt a truly *ecological approach* to the assessment of child behavior disorders in the school setting, however, we will only be dealing with pieces of the overall problem. The continuing practice of evaluating child behavior disorders in isolation from their social context and ignoring the behavioral implications of social agents' perceptions of them, cannot, in the author's opinion, be defended.

## Criteria for Determining Disordered Behavior in the School Setting

Unfortunately, we have approached the problem of identifying child behavior disorders in the school setting as though it were a disease process capable of being isolated and reliably diagnosed. In fact, many of our assessment strategies attempt to apply this exact model to the analysis of problematic child behavior. In the author's opinion, our traditional efforts in this area represent much of what is wrong with current assessment and remediation services.

For example, we act as though we have access to definitional criteria, classification systems, and measurement procedures that will allow us to 1) separate disturbed children from populations of nondisturbed children, 2) distinguish such children reliably from other categories of disability (e.g., learning disabled, mentally retarded), and 3) reliably diagnose different child behavior disorders. It appears that nothing could be further from the truth. For instance, using current definitions, criteria, and methods, prevalence estimates of emotional disturbance in school age populations range anywhere from 0.05% to 40% (Balow, 1979). Further, in a longitudinal study of 1,586 elementary school pupils in over 200 school districts in Minnesota, Rubin and Balow (1978) found that in annual ratings of the sample children in grades K-6, 23-31% were judged by their teachers to be behavior problems in any one year. For children receiving three or more annual ratings, the figure was 59%. Among those receiving six annual ratings, 68% of the boys and 51% of the girls were considered a behavior problem by at least one teacher. Similar findings have been reported by Wherry and Quay (1971), who found that 49.7% of the boys in presumably normal K-2 classes were rated as having behavior problems.

What are we to make of these prevalence estimates? Are we really to be-

lieve that half of our elementary-school-age population is behavior disordered in some sense? This would be analogous to arguing that half of the adult population is neurotic and in need of intensive mental health services. Few professionals would accept the validity of such assertions.

Surveys of the type referred to frequently use checklists of problematic child behavior, have teachers rate all children in their classes on them, and then compute the percentage of children who receive positive ratings on at least one item. It appears *normal* for children to receive positive ratings on some of the more innocuous items in these lists (e.g., restless, distracted, daydreaming). Most children do these things at one time or another. To make a more refined judgment about their impact upon child adjustment or achievement, we need to know their frequency, or rate, or the proportion of time each child engages in them. For example, if a child daydreams 80-90% of the time, there are obvious implications for his or her development or achievement. In contrast, if a child does so 1-2% of the time, there probably are no such implications. In making judgments of this nature, we need to know the kinds of behavioral items checked as well as the number checked. A child who receives 25 out of 50 items (problematic) checked on a checklist is likely to be very different from one who receives two, three, or four items checked. Similarly, two children can receive the same number of items checked but also be very different (e.g., descriptors of severe versus relatively innocuous behavioral problems with equally different implications for development).

In the author's opinion, we need to stop trying to isolate child behavior disorders as unique forms of psychopathology which must be diagnosed in the traditional sense. Existing classification systems do not even generate acceptable levels of diagnostic reliability across clinically trained professionals (Achenbach & Edelbrock, 1978). It is unlikely that we will ever be able to completely separate child behavior disorders in the school setting from other categories of disability.

In the author's view, we would be better off to develop school-based conceptualizations, classification systems, and measurement procedures of those factors that interfere with, disrupt, or are incompatible with educational achievement and social development. We have available to us excellent criterion measures for both academic and social functioning (e.g., achievement tests for academic performance and sociometric measures for social competence). The predictive validity of sociometric measures has proven to be quite strong (Gottman, 1977; Van Hasselt, Hersen, Whitehill, & Bellack, 1979). We also know which classes of academically related child behavior (e.g., attending, compliance, volunteering) facilitate academic achievement (Cobb, 1972). We have an excellent knowledge base relating to disruptive or maladaptive behaviors that actively compete with academic performance. Similarly, Gottman and his colleagues (Gottman, Gonso, & Rasmussen, 1975) have empirically identified social skills that discriminate between popular and unpopular children. They found differences on referential communication skills, knowledge of how to make friends, and frequency of distributing and re-

ceiving positive peer interactions. These measures and empirically based knowledge give us the means to develop cost-effective screening and identification methods and also make it possible to identify dimensions of child academic and social functioning which directly affect child achievement and social competence. We have the technology to increase children's achievement and social competence levels through direct instruction and intervention in the school setting. As long as we cling to our archaic and often irrelevant systems for defining, classifying, and identifying behavior disorders in the school setting, however, many children who desperately need these services will not get them.

We should establish a policy of systematically screening all children in these two broad areas (academic and social functioning) regularly and making services available to those children who need them, regardless of current status or category of disability. Children will, and should, be identified in this process, whose general pattern of classroom behavior is either disruptive of, or incompatible with, academic achievement and social development.

## Procedural Issues

Procedural, as used in this context, refers to assessment practices applied to behavior disordered children and used to make decisions about them. This section begins with a discussion of the variables that directly affect assessment practice. These are: 1) the model of psychological assessment one uses to guide assessment practice, 2) the persons conducting the assessment(s), and 3) the setting(s) in which assessments occur. In the remainder of the section, issues and best practice standards are presented for a series of assessment tasks that are involved in serving the needs of behavior disordered children.

### Models of Psychological Assessment

Coulter and Morrow (1977) argue that psychological assessment has two fundamentally distinct purposes. These are *identification* and *intervention*. Each requires different tests and interpretations of results. They note, as have other investigators (Hobbs, 1975; Kauffman, 1977), that diagnostic labels resulting from the identification process have almost zero implications for the treatment process. They view assessment for intervention purposes as the primary concern of psychologists. It appears, however, that in traditional assessment practice in this area, we have invested far more energy, time, and effort in the identification and problem definition process than in assessment for intervention. There are a variety of assessment models available to guide one's assessment practice. Coulter and Morrow (1977) describe three models (medical, social system, and task analysis) for use in assessment for identification and intervention purposes.

The author recommends consideration of a behavioral model or approach to the full range of assessment tasks relating to the delivery of services to behavior disordered children in the school setting. This approach incorporates many of the assumptions, principles, and recommended practices of the social system and task analysis models described by Coulter and Morrow (1977). Many of the recommendations presented by the author in the first section are based upon behavioral assessment principles.

The nature of a behavioral assessment model, its assumptions, and practices are described in detail by Nelson and Hayes (1979). They describe it as " . . . the identification of meaningful response units and their controlling variables (both current environmental and organismic) for the purposes of understanding and altering human behavior" (p. 491). In this model, behavior is viewed as a *sample* of responding in a particular assessment situation. Unless empirical justification exists, inferences are not made beyond the present behavior and situation to underlying causes, other responses, or different situations. Behavioral assessment includes the measurement of overt motor, physiological-emotional, and cognitive-verbal behaviors. This model encourages recording of multiple measures so as to ensure a broad-band assessment. Characteristically, overt motor behavior is measured via direct observations by trained observers; physiological-emotional and cognitive-verbal behavior is measured by rating scales, checklists, questionnaires, and academic tests.

As noted, behavioral assessment measures both organismic variables and environmental factors within the setting or situation where functioning is considered disordered. Organismic variables include individual differences produced by past learning and physiology. Such variables are often nonalterable. In some cases, however, they are (e.g., correctable sensory impairments). At the very least, assessment of these variables is considered important for an adequate understanding of the disordered behavior.

Assessment of current environmental variables refers to the measurement and analysis of disordered behavior within natural settings and the variables that influence or control it. Situational specificity of behavior is a basic tenet of behavioral assessment. Situations differ in terms of expectations, stimulus conditions, and contingencies, with corresponding differences produced in child behavior. Therefore, it is important to assess child behavior in multiple settings to determine its status and potential for change. Social agents' perceptions of the child's behavior, including generalized behavioral expectations, are an important component of these assessment practices.

In the remainder of this chapter, specific assessment practices that incorporate many of the principles and practices of the behavioral model are reviewed and discussed. In the author's opinion, this model has potential to solve a substantial number of the measurement problems that have traditionally plagued attempts to deliver services to behavior disordered children in the school setting.

## The Persons Conducting Assessments

In the author's opinion, all behavioral assessments of behavior disordered children in the school setting should be coordinated by the school psychologist. If assessments of a specialized nature are required, for example, neurological, neuropsychological, or medical, referrals can be made as deemed appropriate. Whenever possible, behavioral observations should be conducted in those settings where child behavior is considered disordered and by individuals under the school psychologist's supervision (teachers, counselors, aides, student observers).

The classroom teacher's input should be weighed carefully in decisions relating to serving behavior disordered children in the school setting. Traditionally, teacher judgment has not been regarded as either valid or reliable. Wickman's (1928) monograph comparing the attitudes of teachers and clinicians toward the classroom behavior problems of children raised some serious questions about the validity of teacher judgments. In this study, the judgments of psychologists were accepted as a validation criterion against which teacher judgments were compared. The general lack of agreement between the two groups was interpreted as a measure of the teacher's inaccuracy in identifying problematic child behavior. The Wickman study did not test the accuracy of teacher judgment of child behavior—only whether it corresponded with clinicians' judgments. Actual studies of teacher judgment show it to be very accurate (Bolstad, 1974; Greenwood et al., 1979b; Nelson, 1971; Schaefer, in press; Walker, 1970). In particular, teacher judgment is most accurate at the extremes of the distribution, where child behavioral attributes are most salient.

Greenwood et al. (1979b) assessed the accuracy of teacher rankings of child verbal frequency for identifying socially withdrawn children. Of the 26 teachers in the study sample, 23% had identified the lowest interacting child within their first rank. Given three ranks, 65% could identify their lowest interacting child. By five ranks, 77% had identified the lowest interactor. Presumably, teachers would be even more accurate in identifying acting out or disruptive child behavior because of its increased salience.

In addition to their accuracy in judging child behavior, classroom teachers are in an ideal position to identify behavior disordered children. Teachers probably spend more time observing the behavioral characteristics of children in their classes than anyone except parents. It has been estimated that teachers spend 7,000 hours with their pupils in the elementary grades alone. Given this amount of time, teachers should have considerable information to use in making judgments about the behavior of children in their classes.

Teacher nominations, rankings, and ratings can be extremely useful sources of information in the identification and assessment of behavior disorders. Teacher expectations also contribute a great deal of information about the ecology of the classroom and should be systematically measured in the process of defining and evaluating child behavior.

## The Settings in Which Assessments Should Occur

A cardinal rule of behavioral assessment is the need to demonstrate that conclusions reached in the assessment situation can be generalized to the criterion "real-life" situation; that is, where child behavior is considered disordered. Too often, assessments of school behavior disorders fail this simple test of relevance and validity. If a child is exhibiting highly aggressive behavior on the playground, his or her behavior should be assessed in that setting—not in the clinician's office. As a rule, the child's behavior, and social agents' perceptions of it, should be assessed in all settings where it is considered disordered *and* in control settings.

Assessment of child behavior in the home setting as a response to behavior disorders in school is, in some respects, a questionable procedure. Whenever possible, however, it is recommended in order to determine if it is disordered in both settings and to assess parent perceptions of it. As a rule, one will have to rely upon anecdotal reports and ratings from parents. In some cases, parents may be willing to collect data on certain aspects of child behavior or on family interactions. Parent-collected data, however, should be interpreted cautiously in these situations, as it would be highly vulnerable to demand characteristics and response biases (Johnson & Boldstad, 1973).

In vivo assessments of this type are often time consuming and sometimes difficult to obtain. The relevance and quality of the information produced by such assessments, however, will contribute significantly to the delivery of appropriate services to behavior disordered children.

## Assessment Tasks

School professionals are charged with completing a sequence of assessment tasks if behavior disordered children's needs are to be served effectively in the school setting. These are: 1) screening, 2) defining the problem, 3) determining eligibility, 4) selecting target behaviors for intervention, 5) establishing baseline performances, 6) monitoring interventions, 7) evaluating outcomes, and 8) conducting follow-up assessments. Issues are discussed and best practice standards are presented in relation to each of these tasks in the remainder of the paper.

Screening studies show that teachers usually refer from 2-6% of the school age population for special services (Hyde, 1975; Nicholson, 1967; Robbins, Mercer, & Meyers, 1967). Most of these referrals are for children with academic, not behavioral, problems (Kirschenbaum et al., 1977). Those behavior disordered children who are referred tend to exhibit maladaptive behavior patterns that are directed toward the external environment (acting out, disruptive, hyperactive, aggressive) and disturb classroom atmosphere. Children with other types of behavior disorders are not as likely to be referred.

It is apparent that large numbers of children with behavior disorders are

not being referred to needed services. All children in regular classrooms should be screened regularly so that they have an equal chance to be identified for a variety of behavior problems that can interfere with their social and academic development. The teacher referral process, as it traditionally operates, does not accomplish this goal. Systematic screening procedures are needed which require the teacher to evaluate regularly all children in relation to criteria that affect their behavioral status and development.

Kirschenbaum et al. (1977) have demonstrated the feasibility of a mass screening procedure that requires 20 to 40 minutes per classroom. A brief teacher rating form, the AML (Cowen, Dorr, Clarfield, Kreling, McWilliams, Pokracki, Pratt, Terrel, & Wilson, 1973), was used as the primary screening instrument in this study. Previous research on the AML had established its ability to discriminate between groups of maladjusted and normal children. The study found that teachers directly referred 6.9% of the primary grade level children in three inner city schools (n = 698). Mass screening using the AML subsequently identified an additional 9.7% of the population as in need of services. Both groups exhibited significantly more maladaptive behavior than did a normative comparison group on the CARS (Child Activity Rating Scale) (Lorian, Cowen, & Caldwell, 1974), indicating that teachers did not naturally refer all children in need of behavioral services.

Economical, effective screening procedures of this type have significant applicability to the field of behavior disorders. They utilize teacher knowledge of child behavior, yet structure the teacher's judgment so that all children have an equal chance to be identified for behavior disorders. Other excellent systems of this type are available (Clarfield, 1974; Greenwood et al., 1979a).

The author has found teacher rankings of child behavior to be extremely accurate and predictive of status on criterion measures at the extremes of the distribution. Teacher rankings of child academic achievement are also very accurate (Greenwood, Hops, Walker, Guild, Stokes, & Young, 1979). Rather than relying upon teacher nomination for referral purposes, teachers could be regularly asked to rank children in their classrooms on such variables as social competence, appropriate classroom behavior, and achievement. Children at the extremes of the distribution could then be studied and evaluated more thoroughly using such methods as 1) anecdotal records, 2) checklists, 3) rating scales, and 4) observational data. The teacher would thus not have to complete rating instruments on all children in the classroom.

## Problem Definition

Once a child has been screened and identified as in need of behavioral services, it is important to define carefully the specific content of the behavior disorder and to measure the teacher's behavioral expectations and/

or tolerance levels in relation to adaptive and maladaptive child behavior in general (Walker, 1980). There are a variety of checklists and rating instruments available for describing the content of child behavior disorders in school and home settings. Some popular instruments for this purpose are: 1) the Devereux Child Behavior Rating Scales (Spivack & Levine, 1964), 2) the Behavior Problem Checklist (Quay 1977), and 3) the Walker Problem Behavior Identification Checklist (Walker, 1970). Traditionally, such instruments have been heavily weighted toward problematic child behavior. Some recently developed instruments by Achenbach (1979), Gersten (1976), and Walker (1980) contain extensive descriptions of adaptive child behavior as well. Achenbach (1978) has discussed the importance of obtaining ratings and descriptive information on both adaptive and maladaptive forms of child behavior.

The author proposes a three-dimensional model for describing the content of child behavior after systematic screening efforts are concluded. In this model, classroom behavior is rated along a *frequency* dimension and a *critical events* dimension. The frequency index (ratings, counts, codings) is applied to both adaptive and maladaptive forms of classroom behavior. Adaptive behavior facilitates academic performance/achievement and maladaptive behavior disrupts it. The purpose of this index would be to identify maladaptive behaviors the child engages in too frequently and adaptive behaviors that are engaged in too infrequently, for example, excesses and deficits. A sample list of such pinpoints is included in Table 2.

Table 2
Frequency Index of Adaptive and
Maladaptive Classroom Behaviors

| | |
|---|---|
| —Follows classroom rules | —Talks out of turn |
| —Complies with teacher demands | —Gets out of seat |
| —Takes turn | —Whines |
| —Listens to teacher instructions | —Disturbs others |
| —Makes assistance needs known | —Disrupts the class |
| —Produces work of acceptable quality | —Defies the teacher |
| —Attends to assigned tasks | —Does not complete assignments |
| —Volunteers | |

It would also be important to obtain teacher assessment(s) of critical behavioral events that are relatively independent of frequency, yet have serious implications for child status. A *single* occurrence of any of the events listed in Table 3 would be a cause for serious concern by service providers.

The referred child's social competence should be rated by the teacher in specific social skills areas and, whenever possible, assessed with sociometric procedures. The author recommends the following social skills areas: 1) affective skills, 2) interactive skills, 3) approaching others, 4) conversation skills, 5) cooperation, 6) coping skills, and 7) making friends. The child should be compared to peers in each area, that is, the child is less skilled, as skilled, or more skilled than normal peers.

Table 3
Critical Event Index

—Child masturbates in public
—Child assaults an adult
—Child attempts to seriously physically injure another
—Child engages in self-mutilation, e.g., head banging, biting, or cutting oneself
—Child's verbal behavior is irrational and/or incomprehensible
—Child is not in contact with reality
—Child sexually molests another child
—Child threatens suicide
—Child shows evidence of physical abuse
—Child shows evidence of drug use

In fact, normative comparisons of this type are recommended whenever possible on both indirect (teacher ratings) and direct (behavioral observations) measures of child behavior. These sorts of comparisons are helpful in ensuring that the referral is based on actual disordered child behavior and not as a result of other factors. As a general rule, a peer of the same sex should be selected for comparative purposes (Walker & Hops, 1976). If clear differences exist in the two sets of ratings, then the referral is, in all likelihood, more appropriate than if no or only minimal differences exist.

It is also highly recommended that direct observational data be recorded on the child's behavior in those settings where it is considered to be a problem and in at least one setting where it is not (if one exists). Normative peer comparisons should be conducted, if possible, in each setting. This comparison should provide valuable information on levels of appropriate behavior in such settings. There are a number of observational codes and procedures available for use in classroom and playground settings which are easy to use and not too time consuming (Alessi, 1980; Keller, 1980; Walker, 1979). The information yield from such assessments is extremely high and the data usually have substantial relevance to the task of problem definition. As noted, teacher expectations should be measured and the child's perceived behavior problems evaluated in relation to the teacher's standards (instruments for this purpose were described earlier). Finally, it is also recommended that parent ratings be obtained to compare perceptions of child behavior across home and school settings.

## Determining Eligibility

If a child is referred for problematic behavior in the classroom, the child and/or the teacher are in need of some type of service(s) and assistance. As noted earlier, the factors that prompted the referral are unaffected by whether the child meets local, state, and/or federal eligibility criteria. We need to replace our current system of certifying a referred child as ED or BD before *any* services or assistance become available which correspond to the type and severity of the referral problem. This would, of course, be

determined only after a careful analysis of the child's behavior within the referral setting(s) and the social agents' perceptions of the child's behavior problem(s). Eligibility decisions should focus instead on which services or assistance the child's behavior problems require. These could range from simple consultant assistance in the classroom to an intensive behavior management program administered in a special setting. In some cases referral to an outside agency may be warranted.

Fox (Note 2) has conceptualized a least restrictive program of treatment in which available therapeutic services are arranged in a hierarchy of intensiveness and restrictiveness. Whenever possible, one should begin with the least restrictive and least intensive level of treatment that is appropriate and then move to more restrictive levels as warranted. In developing the CORBEH behavior management packages referred to earlier (e.g., CLASS, PASS, PEERS, AND RECESS), the authors used a combination of indirect and direct measures to establish eligibility criteria. These were teacher ratings on specific behavioral pinpoints and behavioral observations recorded on the child's performance in referral setting(s). The purpose of this dual criterion was to obtain a direct measure of the child's behavior as well as the teacher's perception of it and to ensure that the child to whom the program was applied actually warranted the investment of time and energy required in the implementation process. Children who did not qualify were usually exposed only to components of the program or to some other less intensive intervention procedure. Children for whom the program was not successful were recommended for more intensive treatment services.

Setting up specific criteria on both indirect and direct measures of problem behavior to determine eligibility and then correlating them with different levels and types of treatment services or assistance could be generally applied to serving behavior disordered children's needs in the school setting. It is hoped that it would result in a larger number of children being placed in contact with appropriate services.

## Selecting Target Behaviors for Intervention

A great deal of research remains to be done in empirically identifying behavioral correlates of successful classroom adjustment, academic achievement, and social competence. Some important conceptual (Foster & Ritchey, 1979) and empirical (Gottman et al., 1975) work has been directed toward identifying social skills that determine social competence. Similarly, Cobb (1972) empirically identified academic survival skills that were predictive of achievement. Almost no work has been done in identifying those behaviors that distinguish between successful and nonsuccessful classroom adjustment.

Careful descriptive studies in these areas will make future interventions far more precise and cost effective. It is apparent that the same intervention procedure applied to empirically determined target behaviors versus

nonempirically determined behaviors will have vastly different effects on overall adjustment. To date, we have developed a very powerful intervention technology that is applicable to the field of behavior disorders. When our technology of target behavior selection approaches that for intervention, we will be in a position to deliver cost-effective services in the school setting.

Until this technology is completely developed, selecting target behaviors will have to rely to some extent upon the advice of experts, logical analysis, and arbitrary judgment. Social validation techniques have been particularly effective in structuring our judgments in this area (Kazdin, 1977; Van Houten, 1979; Walker & Hops, 1976). Social validation refers to the use of experts, consumers, or significant social agents in rating the importance of behaviors judged to be important as targets of intervention, and whether target responses selected for intervention have changed sufficiently for the treatment to be considered successful. Usually, a Likert-type scale is used for this purpose.

As part of some research on the mainstreaming process, Walker (1980) has assessed receiving teachers' expectations about classroom behavior. Fifty regular and 22 special education teachers responded to an inventory in which they rated the *importance* of adaptive skills and competencies, as well as the degree to which they are or are not *accepting* of maladaptive child behavior. The results indicated that teachers view classroom control and compliance behaviors as most important. Peer-to-peer social skills were viewed as least important. The least accepted child behaviors included stealing, self-abuse, teacher defiance, inappropriate sexual behavior, and tantrums. Interestingly, this list would be characterized as high intensity, low base rate pinpoints. Again, the most acceptable maladaptive behaviors were deficient peer-to-peer social skills. This information tells us what teachers view as important, but it also identifies areas of child performance having powerful implications for development (social skills, for example) which are not viewed as important by teachers.

When designing interventions for behavior disordered children, it is very important to respond to the specific problems that prompted the referral. It is equally important, however, to assess the child's status on behavioral responses that teachers in general see as predictive of good adjustment and also on those that teachers may not view as important, but that are empirically related to achievement, success, or competence.

## Establishing Baseline Performance

Baseline status on target behaviors should be assessed, whenever possible, using direct observational procedures in natural settings so that treatment effects can be evaluated in both intervention and nonintervention settings. Nontarget but related behaviors should also be assessed to determine whether the intervention has only specific or more generalized effects (Kazdin, 1973).

Indirect assessments of child behavior on these pinpoints using ratings or checklists contributed by teachers and/or parents also provide a basis for assessing the perceived impact of an intervention. The combination of direct and indirect assessment can provide for a precise analysis of an intervention's effects. Normative peer comparisons on baseline measures are also to be recommended in this assessment process.

## Monitoring Interventions

Fidelity of implementation has been recognized as a very important factor in the success of any intervention. As a rule, we have assumed that interventions are implemented by social agents (parents and teachers) in the manner that we intend. Unfortunately, such is often not the case.

It is now generally recognized that the implementation process should be measured and documented whenever possible to increase the likelihood of high quality treatment. This would involve keeping careful records on such variables as praise rate, number of time outs, points awarded, points subtracted, privileges selected, frequency of reprimands, and alterations in stimulus conditions. These are essentially process measures that document the extent to which implementation goals are realized. They make it possible to identify sources of treatment failure and to design more effective interventions.

## Evaluating Outcomes

Child outcomes should be evaluated according to 1) absolute gain from pre- to postassessment time points, 2) relative gain in terms of movement toward a normative standard, and 3) assessments of the social significance of the achieved gains. Baseline measures should be administered at *pre-*, *during*, and *post*time points to assess treatment outcomes adequately. The *during* measure provides an assessment of the maximum impact of the intervention on child behavior. The postmeasure is an assessment of short-term maintenance effects. Data recorded on nonreferred peers will make it possible to determine whether intervention has moved the treated child into the normal range. Social validation measures (from teachers and parents) provide information on how the consumer's view changes. Treatments that move performance into the normal range are generally considered successful (Walker & Hops, 1976).

## Conducting Follow-up Assessments

Until the beginning of the 1970s, it was largely assumed that treatment effects automatically generalized to nontreatment settings and were maintained indefinitely over time after intervention was terminated. Systematic assessments in natural settings showed that the opposite was true (Johnson et al., 1976; Stokes & Baer, 1977; Walker & Buckley, 1972;

Walker et al., 1975). Unprogrammed generalization and maintenance of treatment gains is an extremely rare occurrence (see Walker, 1979, for a review of this topic). When it does occur, investigators are usually not able to identify the specific features, elements, or attributes of the intervention accounting for the generalization and/or maintenance effects. Baer, Wolf, and Risley (1968) suggest that generalization should be programmed rather than expected or lamented when it does not occur.

In conducting follow-up assessments of treatments administered to behavior disordered children in the school setting, it is strongly recommended that such measures be taken in all settings where treatment effects are expected to occur. Furthermore, long-term assessments should be made to determine the durability of achieved treatment effects. In those cases where such effects are not achieved, low-cost variations of the original intervention can be implemented to bring child behavior back to criterion levels.

## Conclusion

In the author's view, there needs to be a radical reconceptualization of behavior disorders in the school setting. The assumptions we make about child behavior have a dramatic impact upon assessment practices and the way in which we interpret assessment information. Conclusions based on such information determine the kinds of remediation services eventually made available to behavior disordered children. New definitions of disordered child behavior in the school setting could then be developed from this reconceptualization and be operationalized and translated into measurement strategies and practices that would result in the delivery of relevant, individualized treatment services to identified children.

The author is aware of the complex philosophical, economic, legal, and logistical barriers that would impinge upon these tasks. In many respects, the practices suggested in this chapter represent idealized versions of assessment practice which, if achieved, will likely be years in coming. Professional time is always the critical element in considerations relating to change in existing practices. It is apparent, however, that behavior disordered children are not being adequately assessed or served under our current system. How pressures for change in these areas are incorporated into existing practices, with only limited staff resources available, will be an interesting process to observe in the next few years.

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5i

# Assessment of Severe Behavior Disorders[1]

Bob Algozzine

The terms *behavior disorders* (BD) and *emotional disturbance* (ED) have come to be used interchangeably; in fact, both are used to refer to students "who arouse negative feelings and induce negative behaviors in others" (Kauffman, 1981, p. 4). The passage of Public Law 94-142 (The Education for All Handicapped Children Act of 1975) provided an opportunity for the federal government to propose definitions for categories considered appropriate as federal concerns. The federal definition (for purposes of implementation of PL 94-142) of "seriously emotionally disturbed" follows:

> (i) The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance:
>
> (A) An inability to learn which cannot be explained by intellectual, sensory, or health factors;
>
> (B) An inability to build or maintain satisfactory relationships with peers and teachers;
>
> (C) Inappropriate types of behavior or feelings under normal circumstances;

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[1] Material in this chapter is based on chapters authored by Bob Algozzine which appear in B. Algozzine, R. Schmid, and C. D. Mercer (Eds.), *Childhood behavior disorders: Applied research and educational practice*. Rockville, MD: Aspen Systems Corporation, 1981.

(D) A general pervasive mood of unhappiness or depression; or

(E) A tendency to develop physical symptoms or fears associated with personal or school problems.

(ii) The term includes children who are schizophrenic or autistic. The term does not include children who are socially maladjusted, unless it is determined that they are seriously emotionally disturbed (*Federal Register*, 1977, 42(163), p. 42,478).

Algozzine, Schmid, and Connors (1978) described two major types of disturbed children. The TYPE I (Regular ED) child was characterized as the milder form of behavior problem typically found in regular public school settings; the TYPE II (Clinical ED) child was considered more "severe":

> He/she is the child whose behavior may be problematic in school as well as at home; may be exhibited in favorable and unfavorable school environments; may not be more immediately responsive to environmental management strategies; and/or, may be related to organic inadequacies within the child. (p. 49)

They offered the following definition for use in conceptualizing emotional disturbance:

> The emotionally disturbed child is the student who, after receiving supportive educational assistance and counseling services available to all students, still exhibits persistent and consistent severe to very severe behavioral disabilities which interfere with productive learning processes. This is the student whose inability to achieve adequate academic progress and/or satisfactory interpersonal relationships cannot be attributed primarily to physical, sensory or intellectual deficits. (p. 49)

They also argued that the differences between mildly and severely emotionally disturbed students were a function of the operational criteria used with the definition. For example, the mildly ED student may exhibit interfering behaviors once or twice a day, while the severely ED student might exhibit them once or twice an hour; differences in the actual types of behaviors exhibited also were thought to differentiate the conditions. When Olson, Algozzine, and Schmid (1980) asked teachers to rate a list of characteristics relative to applicability to various types of emotional disturbance, they found mildly and severely ED students were differentiated by the service delivery options and the nature and magnitude of the behaviors exhibited.

Grosenick (1981) writes that

> Severe behavior disorder refers to the most severely handicapped of the children and youth so identified by state and local education agencies for the purpose of federal funding. Included within such a population are students often labeled as delinquent, schizophrenic, autistic, troublemakers, truants, aggressive, acting-out, socially maladjusted, and withdrawn, (e.g., all types of the severest behavior problems that are served or should be served by public and private agencies). These are the children and youth who are primarily in self-contained, segregated classes or facilities. (p. 184)

And while professionals may argue whether *autistic* or *socially maladjusted* students should be included or excluded from the category, the term *severe behavior disorders* (SBD) refers to those students with the most atypical, deviant behavior patterns that differentiate them from other school students.

## Historical Perspective

Society has always separated individuals on the basis of their behavioral differences. The earliest classification system was offered by Hippocrates; he grouped deviance into one of three main categories: mania, phrenitis, or melancholia, and did not differentiate childhood disorders from adult conditions. It was not until the mid-nineteenth century that professionals recognized specific childhood disorders. Prior to that time "abuse, neglect, cruel medical treatment (e.g., bleeding), and excessive punishment were common and often accepted matter-of-factly for children as well as adults who showed undesirable behaviors" (Kauffman, 1981, p. 33). Similarly, during that era, deviance (undesirable behaviors) was viewed as caused by Satanic possession or other supernatural influences; in fact, it was not until the discovery of the cause of general paresis and its eventual cure that the belief in natural causes became more prominent (Ullman & Krasner, 1969). Simultaneously, childhood behavior disorders were "discovered."

According to Kanner (1971), in the early 1900s, Kraepelin grouped a set of characteristics together under the general label of *Dementia praecos*; in so doing, he set into motion the current classification system in psychiatry. Kanner (1971) also reports that at about the same time, De Sanctis referred to a similar set of characteristics as *Dementia praecoccissima* when they appeared in children, and Heller coined the term *Dementia infantalis* for another *child-specific* disorder. In 1943, Kanner described the behavioral symptoms of 11 children, and *early infantile autism* was born. Although the first *Diagnostic and Statistical Manual* (DSM-I) did not contain a separate classification for childhood disorders, DSM-II, published in 1968, contained a major category labeled "Behavior Disorders of Childhood and Adolescence." Severe behavior disorders such as hyperkinetic reaction, withdrawing reaction, overanxious reaction, unsocialized aggressive reaction, and general delinquent reaction were described in DSM-II. In less than a century, disorders of childhood and adolescence had emerged from practical nonexistence to accepted diagnostic classifications.

As is often the case when science proceeds rapidly, considerable confusion characterizes this recent history of severe behavior disorders. For example, the term *childhood psychosis* was used as a general reference to severe behavior disorders; many forms of it were discovered. Mahler (1953) described *symbiotic infantile psychosis*, Rank (1949) discussed the *atypical child*, and Bergman and Escalona (1949) described children

with unusual sensory sensitivity (Kauffman, 1981). Rutter (1968) argued that the failure of professionals to differentiate adequately among conditions of severe disturbance resulted in a poorly conceptualized, impractical body of knowledge relative to treatment of autism. Algozzine and Schmid (1981) put it this way:

> Considerable professional energy and time was expended in activity intended to truly identify the nature and characteristics of this severe disorder. Unfortunately, the results left a great deal to be desired, especially in regard to treatment (Ritvo, 1976). One problem was that different therapists named and viewed the condition from different perspectives; those who saw autism (or whatever they termed it) as a childhood form of schizophrenia used a different theoretical framework and nomenclature than those who viewed the condition as a separate, distinct entity. For two decades differential diagnosis of this condition was in the "eye of the beholder," and little useful substantive theory or research on its characteristics evolved. (p. 58)

By the 1970s, severe behavior disorders of children and adolescents had arrived. Numerous specific conditions were described in the professional literature, and treatment programs in public and private schools were operating (Kauffman, 1981). The common denominator among the various conditions was behavior that was considered significantly different from the accepted norm. The basis for the deviance has been addressed from a number of different perspectives.

In discussing the origins of behavior disorders, Kauffman (1981) emphasized family factors, biological factors, and school factors as important. Conceptual models of child variance and their implications have been analyzed by Rhodes and his colleagues (Rhodes & Head, 1974; Rhodes & Paul, 1978; Rhodes & Tracy, 1972a, 1972b). Discussions of biological, behavioral, psychodynamic, and ecological perspectives of emotional disturbance are presented in Algozzine, Schmid, and Mercer (1981). In fact, the point of view one has relative to the etiology of severe behavior disorders shapes the perspective one maintains with regard to assessment of severe behavior disorders.

## Theoretical Perspectives of Etiology

A variety of theoretical perspectives on the existence of severe behavior disorders have been posited; proponents of each "theory" emphasize different conceptual points in explaining behavioral deviance. Biophysical and psychodynamic models are based more on the idea that "nature" rather than "nurture" is important to health and normalcy. Behavioral and sociological points of view indicate nurturance. Ecological theory is the interactionist perspective.

### Biophysical Model

Although Kurt Vonnegut (1973) is not recognized for his contributions to

theories of severe behavior disorders, he offers an interesting description of one aspect of the biophysical model. He writes,

> that people, mostly men, suffering from the last stages of syphillis, from locomotor ataxia, were common spectacles in downtown Indianapolis and in circus crowds when I was a boy.
>
> Those people were infested with carnivorous little corkscrews which could be seen only with a microscope. The victims' vertebrae were welded together after the corkscrews got through with the meat between. The syphilitics seemed tremendously dignified—erect, eyes straight ahead. (p. 3)

The discovery of the existence of syphilitic spirochetes in the brain of paretic patients and subsequent identification of a biologically based treatment represents one of the underlying notions of biophysical theory; that is, deviant behavior is viewed as caused by abnormally functioning systems, which, if corrected, result in improved behavioral symptoms. Algozzine (1981a) has discussed genetic predispositions, biochemical inconsistencies, and nutritional inadequacies which are thought to cause behavioral disorders. Genetic evidence is offered by the observation that one percent of the general population is afflicted with schizophrenia, 4 to 10 % of individuals whose parents are schizophrenic are also likely to be diagnosed, and 67-86% of monozygotic twins of schizophrenics are similarly affected. Similarly, the finding that some autistic children possess elevated levels of serotonin has led to a considerable amount of biochemical research.

## Psychodynamic Model

Psychodynamic theorists stress the existence of stages of psychological development, which, if violated, may result in deviant behavior. As Moustakas (1953) argued, "impairment of emotional growth during some stage of development with resultant distrust toward self and others and hostility generated from anxiety" (p. 19) may be the cause of psychological *disturbance*. Proponents of this perspective believe that instinctive drives energize psychological life; they also believe there are specific components to one's personality and specific developmental stages for healthy psychological individuality. Various mechanisms and interactions are the psychodynamic bases with which individuals combat the day-to-day stresses and conflicts which threaten "normal" development.

## Behavioral Model

Proponents of the behavioral perspective of severe behavior disorders argue that all behavior is learned in a systematic manner and therefore it is unlearned or changed by following the same set of principles which applied to the initial learning. The behaviorist manages the environment to alter the responses of individuals; the target in intervention is an increase or decrease in the frequency of behavior(s) of the individual thought to be disturbed or disabled. As Kauffman (1981) points out, "two

major assumptions underlie the behavioral model: The essence of the problem is the behavior itself, and the behavior is a function of environmental events" (p. 28).

## Sociological Model

A variety of sociological explanations for the nature and development of deviant behaviors have been proposed (*cf.* Martindale, 1981). Proponents of the *cultural transmission* explanation believe that deviance is learned by association with deviant individuals; they would probably argue against "segregated" special classes and for "mainstreaming," for the positive modeling influences. *Labeling* theorists believe that it is the application of socially sanctioned labels that makes acts "deviant"; rule breaking becomes deviance through conditions that exist outside the rule breaker. *Social disorganization* theorists posit that differences among community members are sources of differences in the prevalence of "deviance"; organized communities with abundant support services produce less deviance than disorganized, "deprived" communities. Sociological theorists focus on external circumstances as the source of severe behavior disorders.

## Ecological Model

Sarason and Doris (1979) point out that interpersonal transactions and relationships are *two-way streets*. Characteristics and behaviors of each of us are effected by (*and* have effects on) the characteristics and behaviors of others. As Algozzine (1981b) indicates,

> Ecological theorists believe that deviance is as much a function of where and *with whom* a child interacts as it is the nature of behaviors that are exhibited by the child (*cf.* Rhodes, 1967, 1970). To these theorists emotional disturbance is in the "eye of the beholder" and is generated or developed when an individual's behavior is viewed as *disturbing* or bothersome by others with whom interaction occurs. Deviance, then is as much a function of *reactions to behavior* as it is the behavior in and of itself. (p. 168)

Each theory for the etiology of severe behavior disorders adds new information; proponents of each have made valuable contributions to our understanding and treatment of behavior problems. A comparison of the major theoretical positions is presented in Table 1.

# Assessment of Severe Behavior Disorders

There are no tests to determine if an individual is severely behaviorally disordered. Performance on tests and actual observations of behavior merely provide information from which inferential judgments are made. These judgments take the form of diagnostic decisions that are thought to

Table 1
Comparative Analysis of Major Theoretical Perspectives

| Theoretical Perspective | Key Proponents | Origin of Disturbance | Focus of Treatment |
|---|---|---|---|
| Biophysical | Rimland<br>Ritvo<br>Bender | Internal imbalances<br>Genetic malfunctioning<br>Nutritional inadequacies | Alteration of presumed causal factors through biophysical therapies |
| Behavioral | Ferster<br>Skinner<br>Hewett | Learning principles<br>Reinforcement<br>Punishment<br>Environmental stimuli<br>Environmental consequences | Alteration of presumed causal factors through behavior therapies |
| Psychodynamic | Freud<br>Adler<br>Erickson<br>Redl | Psychic development<br>Psychological development<br>Internal conflict | Alteration of presumed causal factors through psychotherapies |
| Sociological | Durkheim<br>Goffman<br>Scheff | Social conditions<br>Social sanctions<br>Social disorganization | Alteration of presumed causal factors through social change |
| Ecological | Rhodes<br>Sameroff & Zax<br>Sarason & Doris | Social transactions<br>Personal characteristics<br>Ecosystem imbalances | Alteration of presumed causal factors through ecosystem change |

*Note:* From *Childhood behavior disorders: Applied research and educational practice* by B. Algozzine, R. Schmid, & C. D. Mercer, p. 186, copyright 1981 by Aspen Systems Corporation. Reprinted by permission.

be the best representations of the assessment data. To aid clinicians in this process, a number of catalogs of characteristic symptoms are available; the *Diagnostic and Statistical Manual-III* (DSM- III) of the American Psychiatric Association (1980) is perhaps the best example. The intent of DSM-III and other similar material is to provide operational criteria on which to justify diagnostic decisions.

Diagnostic decision making in psychology and education follows a rather straightforward paradigm. It goes something like this:

*Deviant individuals (A) exhibit certain characteristics (B).*

*Target individual (C) exhibits some characteristics (B).*

*Target individual (C) is deviant (A).*

It can be shown, however, that such reasoning is illogical. Consider the following:

*Cows (A) eat grass (B).*

*You (C) eat grass (B).*

*You (C) are not necessarily a cow (A).*

Because psychoeducational decision-making practices are based on illogical reasoning, problems and issues have arisen.

## Issues in Assessment of Behavior Disorders

The diagnosis, classification, and evaluation of behavior disorders are necessarily subjective acts; in each case, the characteristics of target individuals are analyzed and a decision about the pathological nature of those characteristics is rendered. One could argue that severe behavior disorders, emotional disturbance, psychosis, or any other mental disorders are anything we want them to be. And, in an attempt to reduce the potency of this argument, professionals have come up with definitions for the disorders they believe exist. As Kauffman (1981) puts it, "the definition one *accepts* will reflect how one conceptualizes the problem of disordered behavior and, therefore, will determine what intervention strategies one considers appropriate" (p. 19, italics added). Because definitions are subjective and not universally accepted or followed, however, dilemmas and disappointments permeate the field of severe behavior disorders.

*Definitions.* In 1969 Bower proposed a definition for "emotionally handicapped children"; he suggested that about 10% of the school population fit this category and argued that they exhibited one or more of the following characteristics *over a period of time* and *to a marked extent*:

1. An inability to learn which cannot be explained by intellectual, sensory, or health factors . . .

2. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers . . .
3. Inappropriate types of behavior or feelings under normal circumstances . . .
4. A general, pervasive mood of unhappiness or depression . . .
5. A tendency to develop physical symptoms, pains, or fears associated with personal or school problems. (p. 22-23)

The similarities between this definition of emotionally handicapped children, often considered mildly handicapped (*cf.* Reinert, 1976, Shea, 1978, and others), and the definition supporting the federal initiative to serve "severe" children should be obvious. The assessment problems in this definition should be equally obvious:

1. What is an *inability* to learn? How is it measured? How do we determine it is not due to intellectual, sensory, or health factors? How is it corrected?
2. What are *satisfactory* interpersonal relationships? How are they measured?
3. What behaviors are *inappropriate* under normal circumstances? What scale is used to determine their inappropriateness? What are normal circumstances?
4. What is a pervasive mood of *unhappiness*? How is it measured? How is it corrected?

Regardless of *which* definition one subscribes to relative to the definition of behavior disorders, the simple fact remains that the severe (or any other) behavior disorders are subjectively derived by professionals who believe it is important to serve children with problem behaviors. Unfortunately, this humanitarian ideal has resulted in some dilemmas and disappointments for those same professionals.

*Dilemmas.* How many children are handicapped by severe behavior disorders? This question has important significance for assessment because it is the *numbers of children* which are often the basis for the *dollars for children*. The provisions of PL 94-142 provide that the federal government will supply 40% of the excess costs of educating a handicapped child. At a practical level, more children identified as handicapped means more federal dollars for support. "The actual numbers (i.e., prevalence) of children with behavior disorders have varied from about .5% of the school population to 20% or more" (Kauffman, 1981, p. 22). This variance is not surprising. Considering the state-of-the-art in definition, we may find as many children with severe behavior disorders as is *economically profitable* (*cf.* Kauffman, 1980).

*Disappointments.* The validity of the logical paradigm on which diagnostic decisions are made rests on the extent to which universal and specific characteristics are used for class inclusion. If all (universal) cows eat grass *and* if only (specific) they do it, then, if you eat grass, you are a cow. The characteristics used for class inclusion in the category of behavior

disorders are anything but universal and specific. Therefore, the reliability of diagnostic decision making based on these characteristics has been low. Schwartz and Johnson (1981) report data compiled by Rimland (1971) relative to "agreement between pairs of diagnosticians on the diagnosis assigned to 445 children showing severe behavior disorders" (p. 118); the agreement among the diagnosticians ranged from 0-38%. The extent to which two or more clinicians, using a given system, can arrive at a similar diagnosis after independently assessing the same individual has been a problem in the area of severe behavior disorders. Studies using the DSM-I and DSM-II categories for adult disorders have been completed. Beck, Ward, Mendelson, Mock, and Erbaugh (1962) found that psychiatrists, acting independently, agreed on the diagnosis of schizophrenia in 54% of the cases; agreement on subcategories within broad groups was even lower. Analyses of the work of others has indicated similar results; that is, reliable judgments can be made only if broad (e.g., psychotic, neurotic, etc.) diagnostic groupings of adult disorders are evaluated (Sandifer, Pettus, & Quade, 1964; Schmidt & Fonda, 1956; Schwartz & Johnson, 1981; Ullman & Krasner, 1969).

Cantwell and his colleagues (Cantwell, Mattison, Russell, & Will, 1979; Mattison, Cantwell, Russell, & Will, 1979) conducted a series of studies evaluating diagnostic decisions made about children using the DSM-II and DSM-III categories; their results support the statement of Schwartz and Johnson (1981): "Judges tend to disagree more often about specific diagnoses, and interjudge reliability for specific diagnoses has often been found to be unacceptably low (p. 58)." They later add:

> Difficulties in differentiating between autism and various other conditions exhibiting autistic-like symptoms were shown to stem from the tendency of many diagnosticians to use undefined, vague terms when describing psychotic symptoms or to use the terms "autism" and "schizophrenia" very broadly. . . . The lack of agreement among professionals is an important problem for clinicians and researchers. (p. 117)

Severe behavior disorders as an area of professional concern is an amalgam of theory, philosophy, and subjective decision making. Current assessment practices reflect as well as contribute to a less than optimal state-of-the-art. Disregarding the problems that characterize the assessment practices in severe behavior disorders, the diagnosing of children goes on; the hope, of course, is that the benefits of treatment will outweigh any disadvantages of identification. Within this context, assessment practices follow several different perspectives.

## Assessment Perspectives

Assessment results serve many purposes; they are the basis for screening, identification, intervention, and evaluation. All assessment information is the result of an interview, an observation, or a clinical judgment. The nature of the information will vary as a function of the assessment per-

spective of the clinician. And while there may be no "pure" theoretical assessment battery, a discussion of typical information that is collected and analyzed relative to various theoretical points of view is presented.

## Biophysical Assessment

As Algozzine (1981) indicates, "the presence and extent of abnormal body functions is determined by medically oriented examinations; such assessments include collection of historical information as well as analysis of various types of physical and biological functioning" (p. 93). This information includes a *history* in which areas of personal and interpersonal functioning are assessed, as well as various neurological and laboratory tests. Information about the family development and present condition is collected in a complete medical history. A neurological examination includes assessment of consciousness and mental state; cranial nerve, motor, reflex, cerebellar, and sensory system functioning; and consultative assessments (e.g., electroencephalogram, brain scan, computerized transaxial tomography, etc.) as deemed necessary by a neurologist.

Typical laboratory tests evaluate the body fluids (i.e., blood and urine). In some instances, a Serum Multi Automated Computer (SMAC) analysis is performed; it includes 18-25 blood tests. Analysis of body chemical levels tells physicians and clinical pharmacists a great deal about various body functions. For example, an elevated level of blood glucose is suggestive of a disorder in glucose metabolism.

## Psychodynamic Assessment

Psychological development and personality components as conceptualized by psychodynamic theorists can not be directly observed; psychodynamic assessment relies on clinical interpretation of test performance and information collected in interviews. The assessment process is used to obtain information about the individual's development and personality characteristics to be compared to that of normal individuals; after all, normal people (A), however we define normalcy, exhibit certain characteristics (B), and, cows eat grass.

A frequently used personality test is the Rorschach Ink Blots; it consists of five achromatic and five chromatic inkblots about which free association, inquiry, and limit testing responses are elicited. The nature of the responses is evaluated and compared to performance of "clinical" populations for interpretation. For example, Levi and Kraemer (1952) reported that a greater than average number of human movement (M) responses in children was associated with provoking, attention-getting behaviors, and severe temper tantrums. A trained clinician would interpret similar responses (i.e., M responses) as indicative of similar deviant behaviors.

Similar analyses of intellectual performance (IQ) on the Wechsler scales serve as another basis for assessment of psychological development and functioning. For example, findings of Verbal IQ scores significantly above Performance IQ scores have been reported for most mental disorders. Performance IQ scores significantly higher than Verbal IQ scores are thought to be representative of acting out disorders (*cf.* Ogdon, 1969). Unusually low information scores are thought to be indicative of repressive defenses; unusually low Digit Span scores suggest possible manic-depressive conditions (*cf.* Ogdon, 1969).

The basis for clinical interpretation of interview data and test performance is the undistributed middle term argument discussed earlier. Research and observations reveal that hyperactive or anxious individuals (A) score low on the Digit Span subtest (B). Assessment results indicate that an examinee (C) scores low on the Digit Span subtest (B); it is concluded that the examinee (C) is a hyperactive or anxious individual (A).

## Behavioral Assessment

The behavioral approach to assessment is based on the conceptual framework in which behaviorists view deviance; that is, behaviorists address the extent of individual behavioral deficits or excesses as well as the quality of environmental control (e.g., reinforcements, punishments, etc.). For example, if a child is referred for hyperactive behavior, the behavioral psychologist would first develop a clear definition of the target behavior and then determine the extent of the behavior and any environmental variables that influence the behavior. Typically, one behavior at a time is addressed; usually the most maladaptive is addressed first. Various properties of the behavior may be observed; that is, *frequency*, *duration*, *inter-response time*, and *latency* are observable (Criswell, 1981). Additionally, information *about* the behavior may be collected in interviews (Mash & Terdal, 1981). When an adequate analysis of the problem has been completed, plans for intervention are initiated; follow-up assessments are used to evaluate progress. Descriptive analyses characterize behavioral assessments; that is, the nature of the behavior is mapped and interventions are implemented and evaluated.

## Sociological Assessment

Characteristics of the family constellation, home environments, siblings and peers, and "significant others" are evaluated in assessments based on the sociological model. This may be accomplished by conducting structured interviews or sociometric procedures. For example, by asking teachers and classmates about a particular child, some measure of social status may be obtained. Similarly, by observing classroom interactions, social relationships in school can be evaluated. Parental attitudes toward school and other social functions are also important in a sociological assessment; they may be evaluated through interviews or direct observa-

tions during a home visit. Family interactions provide information for analyses of social functioning. The exact information collected in any assessment will vary as a function of the orientation of the evaluator. And, while a behavioral sociologist might collect different information than a psychodynamic one, data obtained in a sociological assessment will be used to explain deviance in terms of environmental influences.

## Ecological Assessment

From the ecological perspective, the extent to which ecosystem characteristics and child characteristics *match* is the basis for defining deviance. In an ecological assessment, factors that contribute to the presence or absence of deviance are identified and used to plan interventions. The collection of appropriate ecological assessment information is accomplished in several ways. Ecosystem members may be asked to report or analyze their tolerances and expectations for selected characteristics (Algozzine, 1981). The extent of "match" between salient characteristics (in the individual) and tolerances or expectations is evaluated; ecological disturbance is more probable when high frequency behaviors are less tolerated by significant ecosystem members. Intervention can then be planned to address any component of the ecological disturbance; that is, level of behavior may be altered or levels of tolerance may be altered or some combination of the two may be planned.

There is no clear-cut, simple procedure for determining if a child's behavior is disordered; in fact, the decision is subjectively derived. Determining if behavior is *severely* disordered simply adds one more level of subjectivity. This in no way implies that some of us do not have problems in school or with interpersonal relationships. It merely argues that those problems are not necessarily ours; in fact, they belong to all individuals who participate in defining them.

The traditional approach to assessment is based on illogical reasoning. Simply because you exhibit characteristics that are observed in deviant individuals does *not* mean you are deviant. In fact, being identified as deviant in that sense has little or no prognostic, practical value. Its continuing practice has led to some critical issues in the area of assessment (*cf.* Algozzine, 1980; Ysseldyke & Algozzine, 1982).

An alternative approach can be formulated in which it is argued that certain behaviors (A) are bothersome to others (B). If you (C) engage in those behaviors (A), we can conclude that you (C) will be bothersome to others (B). The logical validity of the argument depends on practical concerns; that is, the extent to which there are bothersome behaviors and the extent to which you do them are empirical issues. From a treatment or prognostic standpoint, this approach is encouraging because the nature of the problem is obvious (i.e., your behavior is the source of concern in others). There is no need to dwell on the significance; we merely identify the behavior(s) of concern and then program for change.

## Assessment Model

The following general steps may help in formulating a model to guide alternative assessment practices for severe behavior disorders. Naturally, they are an amalgam of the previously discussed assessment perspectives (e.g., biophysical, behavioral, etc.).

*Step 1.* Observe the ecology. No behavior or problem occurs in a vacuum. The expectations and tolerances of teachers, parents, peers, and others are important determinants of behavior; they may vary from family to family, school to school, teacher to teacher, or child to child. Whenever possible, this information should be collected *prior to* a formal referral; information collected in an unobtrusive manner may differ from that collected after a referral is made and additional expectations are generated. Information on the internal constraints/external pressures present in a particular school or class may prove very useful in conceptualizing and dealing with *the problem*.

*Step 2.* Select and define target behaviors. Behavior disorders (severe or otherwise) exist because of behaviors. Often it is not easy to identify the specific behavior that presents the problem; in many instances, many behaviors are of concern. The fact remains, however, that it is behavior that causes parents, teachers and others to address the idea of behavior disorders. Target behaviors that have high ecological significance should be identified; these same behaviors can become the focus of subsequent interventions.

*Step 3.* Observe the behavior(s) of the target individual. If an adequate definition of the behavior has been developed, it will be observable. Observations should be collected by different individuals in different settings at different times. Similarly, corroborative evidence (i.e., results of interviews, behavioral ratings, etc.) should be collected from several sources to identify the extent of the behavior in the target individual.

*Step 4.* Observe the behavior in a target random peer. Some information on the extent to which the problem behavior(s) occurs in other individuals should also be collected. The collection of these data should follow the same procedures that were used for the target individual. This step may be repeated several times to ensure an adequate sample of the behavior of others.

*Step 5. Address the extent of the problem.* If similar data have been collected, comparisons of a current rather than historical nature can be completed. Such comparisons can be useful in identifying the exact nature of the problem. For example, the context and extent of the child's problem can be evaluated in reference to standards set by the classroom peer(s). Similarly, information about how different a child actually is can be useful in working with teachers. Often, without such an analysis, the target child appears to be more of a problem than he or she actually is.

*Step 6. Search for a cause.* Once the characteristics of the behavior and related factors have been identified, possible causes should be evaluated. For example, restlessness or inattentiveness may be caused by dietary inadequacies, biochemical imbalances, inappropriate contingencies, family traits, teacher intolerances, or many other factors. By exhausting and possibly identifying probable causes, appropriate treatment perspectives may be facilitated. Clearly, the best assessment is one that addresses all possible causes for the problem.

*Step 7. Formulate treatment strategies.* At best, the information collected during *any* assessment is the basis for formulating *tentative hypotheses* about the nature and extent of a problem. For this reason, the real value of engaging in assessment rests in the extent to which productive treatment strategies can be identified and implemented. In developing intervention plans, the assessment results should be used to guide decision making relative to alternatives available (i.e., ecological options). The plan(s) should also include a time frame for evaluation.

*Step 8. Intervene.* The proposed intervention should be conducted for a specified period of time. During the intervention, assessment data similar to that collected previously should also be collected. The data provide the basis for evaluating the effectiveness of the intervention.

*Step 9. Evaluate the intervention.* Because *tentative* hypotheses are the basis for treatment plans, the evaluation of any intervention should be a mandatory step in the assessment process. Without it, we are engaging in poorly conceptualized and conducted research with human subjects. Because we are often engaging in an activity that is based on subjectively derived problems, we owe it to our clients to evaluate the results of our efforts. The results of such a procedure become the basis for reengaging the proposed model at an earlier step or for deciding that we have successfully "cured" the problem.

## Assessment Perspective

As with any model, that proposed is only limited by the value it accrues from use. Because it is being presented for use here, its current value is unknown. The value of the traditional model has been established. The practice of observing characteristics of target individuals (directly or through ratings and inference) and comparing them to lists of "psychopathology" has resulted in a state-of-the-art that is impressive only because it is provocative. Practitioners, of course, have the option of continuing to add to the dilemmas and disappointments which characterize current assessment practices or engaging in a different model of assessment.

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# A Model for the Differential Assessment and Placement of Emotionally Disturbed Students in Special Education Programs

Sheldon Braaten

It is widely recognized that there are large numbers of children and youth whose behavior is disturbing to such a degree that they require the specialized services of trained professionals. While this recognition is not new, widespread concern and the mandate for effective intervention programs is quite recent. For years, adults and children alike who were identified as "mentally ill" were segregated from the mainstream of society, often with little hope of returning to their natural environments. With the increasing knowledge in the area of emotional disturbance, a major shift in approaches emerged during the 1950s and 1960s. In 1964, Morse, Cutler, and Fink wrote, "we have come to recognize that the treatment of the patient in his normal life situation . . . is a powerful tool in our efforts" (p. 1).

This view has been most dramatically demonstrated by the emergence of public school programs and services for emotionally disturbed students. It was logical that schools become a major focus for intervention programs because of their extensive contact with children, personnel resources, and pressures from teachers and parents to work with students having social or emotional problems. Increasingly, total treatment programs have become viewed as a responsibility of educators (Hammill & Bartel, 1975). Evans and Nelson (1977) noted that for many students, "School experience alone was effective in the socialization and intellectual development of children with problem behavior and that access to a comprehensive mental health program was of no additional benefit" (p. 605).

Since 1977 the most compelling influence on school programs has been the mandate of PL 94-142, requiring that all handicapped children and youth be provided "appropriate" special education services in the "least restrictive environment." Key words in the mandate are "appropriate" and "least restrictive environment." The requirements of the law place on educators the responsibility to: 1) identify the problems and needs of children accurately; 2) determine the most effective interventions; and 3) determine and implement a program designed to foster social, emotional, and academic growth. The extent to which educators meet this responsibility is dependent, in part, on their effort and ability to assess the problems of children accurately, and to develop interventions differentially.

Apart from providing the critical programs and services, the tasks of assessment and determining appropriate interventions have proved to be complex and often frustrating. Unlike the instruments and processes of assessment for the hearing or visually impaired or the physically handicapped, the processes for determining appropriate services for the emotionally disturbed are not precise and are complicated by variables other than the student's behavior.

## Definition

The problems begin with deciding who is "disturbed," or what constitutes emotional disturbance. There is little agreement on a definition (Grosenick & Huntze, 1980; Hewett & Taylor, 1980; Wood & Lakin, 1979). Generally, the definitions used reflect the theoretical perceptions of the individual or organization performing the assessment, and have historically influenced the assessment process itself, as well as the implications for interventions (Bullock & Zayer, 1980; Newcomer, 1980; Rhodes & Tracy, 1972). Thus, the first assessment issue for educators is which theoretical assumptions to use as a basis for criteria to identify emotionally disturbed children. Four of the most prevalent models are the psychoanalytical model, the sociological model, the behavioral model, and the ecological model. Each of these models is discussed in detail in other chapters of this volume and the reader may review those discussions for descriptions of the implications of theories on assessment practices.

Definition is an important issue in assessment because it shapes perceptions and influences the process itself. Traditionally, definitions are the basis for classifying (Hewett & Taylor, 1980), comparing (Howell & McGlothlin, 1978), and labeling (Wood & Lakin, 1979) problem behavior. These processes are based on the assumption that problem behavior can be defined and categorized in such a way that the diagnostician(s) can then assign a label and prescribe an intervention.

Unfortunately, the existing definitions have not provided a reliable means for bridging the gap between classification and intervention. Behavior that is viewed by one person as merely different may be viewed by

another as a disorder (Kauffman, 1979). Topographically similar behavior in one instance may be defined as an impairment, while in another as emotionally disturbed, and in still another, as maladaptive. In each instance, the definition chosen by the evaluators may imply a different kind of intervention. Further, no specific behavior in itself is abnormal. Because of this issue Kauffman concluded, ". . . our experience as special educators has demonstrated the utter futility of trying to achieve diagnostic purity (p. 59)."

Another problem with definitions is the potential negative effects of the labels that accompany them. One view is that there is something negative and even hostile in defining and labeling children as emotionally disturbed (Wood, 1981). The labeler is in a powerful, decision-making position and the labeled individual becomes vulnerable to a self-fulfilling prophecy. Minority and lower socioeconomic groups are particularly at risk in school settings. According to Wood,

> The opinion of the teacher, and the administrator . . . supplemented perhaps by a statement from a social worker or school psychologist, is usually sufficient to establish the "need" for special programming for behavioral reasons of a low socioeconomic status student. By contrast, outside support in the form of a full clinical report may be necessary in the case of his or her higher socioeconomic status classmate. (p. 53)

Wood stresses that evaluators can minimize the intrusiveness of labels if they understand labeling and assessment as a process, introduce as much detailed and objective descriptions of behavior as possible into the record, and rely on group rather than individual decisions. We are reminded that, "In the end, labels are not assigned on the basis of ratings, observations, or test scores, but by people interpreting and valuing such data" (Wood & Lakin, 1979, p. 9). The process must be done with particular sensitivity and, according to Morse, "should generate trust, and insight with the child, parent and educators" (1979, p. 9).

Despite their problems, definitions and labels do have a positive function—they entitle the student to services. From an administrative perspective, definitions are included in rules and regulations to guide the delivery of services (Cullinan & Epstein, 1979). They determine how programs are communicated to parents, students, and the community. They may dictate certain aspects of the program that are to be included. And, they may potentially affect the number of students to be served.

If the assessment process relies on a definition that serves primarily as an administrative means to provide services, then the basic issue becomes establishing criteria for a good definition. Wood and Lakin (1979) proposed four elements of a good definition and two others that concern the use that we make of them. They are presented in the form of questions:

(1) The "disturber" element: What or who is perceived to be the focus of the problem?

(2) The "problem behavior" element: How is the problem behavior described?

(3) The "setting" element: In what setting does the problem behavior occur?

(4) The "disturbed" element: Who regards the behavior as a problem?

And the questions that relate to the use we can make of the definition:

(5) The "operationalizing" element: Through what operations and by whom is the definition used to differentiate disturbers from nondisturbers or to access the needs of disturbers?

(6) The "utility" element: Does the definition . . . provide the basis for planning activities that will benefit those labeled . . . . (pp. 7-8)

Definitions must be perceived in relation to what the student needs in order to achieve. They should serve as a guide for interventions that will be implemented. In this sense, definition may be viewed as the outcome of the assessment process, rather than a set of criteria from which to choose a label.

The current educational definition used in the regulations implementing PL 94-142 refers to "Behavioral Disabilities" as those characteristics that adversely affect educational performance to a marked degree over a long period of time. As it is presented in the law, the definition falls short of meeting the criteria previously presented. It leaves it to the individuals using the definition to develop the elements that will make it operational. On the surface, this limitation may be viewed as a major weakness, but it can also be a major asset. If viewed from the ecological perspective, it allows for variance in perceptions and recognizes disturbance as a relative phenomenon. Its most important function for educators is the focus on characteristics that adversely effect learning.

## The Assessment Process

Simply stated, assessment is a decision-making process. The primary objective is to identify student needs and determine interventions. The purpose is planning, rather than assigning labels. Evaluators are concerned about the individual and his or her idiosyncratic nuances, according to Morse (1979), but "it is just as critical to evaluate the nature of the environment as the person" (p. 22). Assessment must be prescriptive. "It can be considered an exploratory strategy rather than a routine application of specific procedures" (Evans & Nelson, 1977, p. 610).

There has been an overreliance on traditional psychometrics and routinely administered test batteries, which has not proved very useful for diagnosing behavior management problems (Kauffman, 1979). "Appropriate evaluation techniques," according to Howell, "define variables, delineate the objectives . . . and focus intervention" (1981, p. 34). This does not imply that psychometrics should be abandoned; rather it emphasizes that,

> . . . in assessment the prescriptive (describing behavioral deficits and assets as a starting point for a treatment program) and evaluative (providing an objective measure of the child's progress) functions of assessment are much more significant than the diagnostic (describing the child with reference to some comparison population) or predictive (estimating the child's probable status at a later point in time). (Evans & Nelson, 1977, p. 608)

Few would argue with the prescriptive function of assessment. The challenge has been to develop models for directly linking assessment data to interventions. In education settings, where the mandate requires "appropriate" programs in the "least restrictive environment," the question becomes, by what criteria do evaluators decide that the student should be served within the regular classroom, resource room, special class, special school, or residential program? Deno's (1970) Cascade model describes levels of service based on the severity of problems. As the severity increases, the level of intervention increases. Students with the least severe problems are handled in regular classrooms and, where necessary, teachers make use of consultation, supplementary teaching, or treatment. Students with more serious problems receive additional help in resource rooms or special classes. Students with severe problems are served in special schools, residential schools, or hospitals. In this model, the assessment team decides not only what interventions are appropriate, but also in what environment they should be employed.

## Prescriptive Assessment Models

Efforts to link assessment data to specific interventions have provided a variety of models that are used in educational settings. The behavioral model is perhaps the most succinct and commonly used prescriptive assessment process. Its simplicity and direct link to interventions for identified problem behaviors make it attractive to educators. While it has repeatedly been demonstrated as an efficacious approach in varied settings and for many kinds of behaviors, it does not provide a clear framework for deciding at which service level on the cascade to employ interventions. By itself, the behavioral model is not a system or process for deciding how far up the cascade the referral must go for interventions to be effective and still meet the least restrictive criteria. Another way of describing the model's limitation is that it is difficult to differentiate severity in terms of response frequencies alone. It is probably the most useful approach for planning interventions that are to be applied in the setting where the problem behavior is occurring.

Newcomer (1980) described a model for classifying and determining the severity of problem behavior which includes 14 different assessment variables (e.g., intensity - how disruptive; appropriateness - how reasonable; frequency; duration; specificity, generality - how many situations). She has attempted to operationalize such variables by developing a three-level scale with criteria for "Normal," "Problem," and "Referable" be-

haviors. For example, a variable is described as "normal" when it has "little or no effect on others." "Problem" describes behavior that has "considerable effect on others." Behavior that has an "excessive effect on others" is called "referable." The classification criteria are accompanied by additional criteria for determining the degree of disturbance, expressed in terms of mild, moderate, and severe. An example from this component is social functioning, where mild disturbance is described as "usually able to relate to others." Moderate is defined as "usually unable to relate to others" and severe is defined as "not able to relate to others" (p. 111). Newcomer's model includes a structure for operationalizing referral criteria, but is limited because it is primarily a screening rather than a prescriptive approach and it falls short of linking assessment data to levels of service.

Gearhart and Willenberg (1974) described a tridimensional prescriptive educational model, which calls for determining the student's needs, deciding a course of action, and implementing a remediation plan. The three dimensions of the model are needs assessment, contingency management, and resource allocation. The conceptual model was developed primarily for use with instructional rather than behavioral problems, but it does suggest a prescriptive structure for organizing behavioral data with specific attention to required resources. It does not include a structure for determining an appropriate service level of intervention for behavior problems.

Hewett and Taylor (1980) suggest that the gap between assessment data and practice can be bridged by comparing the student to one of six levels of learning competence and converting "disturbance" to "lack of competence." They say "This lack of competence, when specifically stated, becomes the educational definition of emotional disturbance for the child and provides a direct link to the setting of curriculum goals" (p. 99). The six successive levels of competence are: attention, response (motor and verbal), order, exploratory, social, and mastery. Evaluation consists of determining at what level of competency the student is functioning and the negative behavior variants (too much or too little at each level). Each learning competency level includes a list of objectives from which intervention plans are determined.

Two advantages of the Hewett-Taylor model are that it determines definition by student's learning needs, and that the learning competencies are sequenced in such a way that they are linked to different kinds of interventions. Like the behavior model, however, the objective-intervention links appear to be within a given environment. The competency levels are not discussed in relation to the Cascade model and are highly suggestive of assessment and intervention within a special class. It is not clear from the levels of learning competency and the learning goals how evaluators should decide whether to select a regular class, resource room, special class, or special school for the student.

Howell (1981) reviewed 200 randomly selected descriptions of assess-

ment processes in educational settings. He found that all of them could be described on three dimensions. The first dimension includes the types of instruments used—rating scales, observation, tests, and interviews. The second dimension is the source of data—client, professional, family, and peers. The third dimension is the orientation of the evaluator—client centered or situation centered. He concluded that most procedures summarize behavior, but do not provide operational standards to which behavior can be compared. Evaluator's intuition has been the operational standard. Even the "behavioral" observations and rating, which provide an alternative to projective assessment, he says, "are often nothing more than sophisticated behavior summaries" (p. 39).

Howell & McGlothlin (1978) suggested an ecobehavioral approach to assessment, in which behavior is viewed in the context in which it occurs. Evaluators must remember that "disturbed" children do not have a monopoly on problem behavior. Often, disturbing behaviors are quite understandable and perhaps even appropriate responses to environments that fail to meet children's legitimate needs. Curran and Algozzine (1980) have described evidence that supports the view that teachers respond differently to disturbing behavior and suggest that relationships can be optimized by carefully considering the effect each has on the other.

Given the fact that we have no precise instruments or methods for assessing disturbing behaviors and for determining interventions, assessment models must attempt to describe the optimal parameters. Further, it is inevitable that assessment information be subjected to clinical judgment. Therefore, Morse concluded that,

> Each working group . . . which makes up the special education team will have to develop dimensions which are critical to them and decide how to go about assessing these dimensions. If they do not, the expensive effort of identification will end up with the label assigned, rather than knowing the student. (1978, p. 11)

Zabel, Peterson, Smith, and White (1981) questioned teachers and identified 15 types of information which are typically included in special education placement as well as in reentry assessments. They include IQ scores; standardized achievement scores; psychological reports; vision, hearing, and language screening; health histories and family information; teacher assessments of anecdotal records and behavioral status; criterion-referenced academic evaluations; statements of educational and behavioral goals; subjective evaluations of student needs; interventions already attempted; expected data for achieving goals; behavior rating scales and checklists; descriptions of regular class expectations; formal observation data; and sociometric self-concept data. The following proposed model will describe a process by which these kinds of information can be organized to form direct links to the levels of intervention on the Cascade model.

# A Model for Assessment and Placement

A conceptual model of assessment, which will provide for differential evaluation and placements of students, must be broad enough in scope to weigh the full range of problem behaviors, from those considered mild to the most disturbing or severe. In the area of human behavior, where values and perceptions are inescapably part of the evaluation process, any approach will be imperfect. The goal here is to organize subjectivity in a way that enables evaluators to plan interventions and placements within the context of a full range of special education services. It is assumed here that the foremost question is how to match services to students' needs, rather than what diagnostic label to apply to their problems. It is also assumed that the assessment and intervention decisions are completed by a multidisciplinary group, rather than by an individual.

The sections that follow present a model for decision making. Detailed descriptions of information that should be considered are included, but the assessment team must decide how to obtain data and who will be responsible. The sections are: identification, chronicity, observational measures, personality and behavioral patterns, academic achievment, medical/physical severity factors, response to interventions, positive student attributes, and environmental characteristics. Finally, a conceptual model is presented in which the gathered data can be integrated in a structured way to determine appropriate placement and intervention decisions.

## Assessment Variables

*Identification: Situational Versus Pervasive.* The first step is the identification of a problem. The focus is to determine who perceives the referred student's behavior as a problem, where the behavior occurs, and under what circumstances. Information is collected from reports and interviews with individuals in all of the primary elements of the student's ecosystem: home, community, and school, as well as from the student. the initial task is to determine the extent to which the student's behavior is perceived as consistent across settings or is associated with specific situations. Questions that will determine the pervasiveness of the problem behavior are organized into the elements of the student's environment, beginning with the school.

*In school.* It is important to have clear and comprehensive information from the school setting. The data should answer how the student responds to teachers, classes, or academic tasks, time of day, support staff, administrators, and peers.

1. *Teachers.* Which teacher(s) has indicated a concern about the students? Does the student appear to respond differently to teachers on the basis of their experience, gender, age, or race?

2. *Classes.* How does the student behave in high competency classes such as English, math, or science, or other required classes in which he or she is not interested, compared with those the student appears to enjoy? Is there a different response to various learning situations: large versus small groups, active versus passive, high versus low structure? Are assigned tasks accepted, attempted, and completed?

3. *Place.* Where do the perceived problems occur: classroom, hall, gym, lunchroom, lavatories, school grounds, bus?

4. *Time.* Are the problems consistently noted at the beginning, middle, or end of the school day, or before or after a specific class? Do they appear to increase as the day progresses?

5. *Support Staff.* How does the student respond to the social worker, counselor, nurse, or other support staff? Does he or she seek and accept guidance?

6. *Administration.* How does the student respond to the principal? How often is he or she suspended or referred to the office for discipline problems? Is the administrator used by staff as a reinforcer for positive behaviors?

7. *Peers.* How is the student perceived by peers? Does he or she appear to respond differently to peer groups based on characteristics such as sex, age, or race?

*At home.* Obtaining accurate and reliable information from parents is often difficult for a variety of reasons. Parents are generally not familiar with the jargon used by professionals and many parents are not skillful in expressing themselves. All too often they feel distrustful and threatened, or are angry for what they may regard as injustices to their child. Whether the parents have initiated the assessment themselves or are responding to a school concern, be they supportive or hostile, it is important that they be interviewed by sensitive and skillful staff. The task, again, is to learn how the student is perceived at home, by parents, siblings, and other relatives, with respect to duties, responsibilities, use of unstructured time, hobbies or special interests, and so on.

*In the community.* Accurate information about the student's behavior in the community is typically the most difficult to collect. Often the assessment team must rely again on the parents for much of the data. Any information that can be collected is helpful in completing a description of the student's behavioral patterns. Reports should include descriptions of the student's relationships with peers and adults in the neighborhood as well as in any social or recreational organization. If public authorities are involved, such as county welfare workers or the courts, their concerns and records should be included. Also, if public or private service agencies, such as a mental health center, have been involved, their findings are important. Finally, if the student has had a job(s), information about performance and relationships is helpful.

*Self.* Most often referrals are initiated by teachers or parents, but some students do seek help themselves. Regardless of how the student is identified, his or her perception is also important to the intervention planning process. With older students, particularly adolescents, their perceptions of themselves and others may have a significant bearing on interventions that may be recommended.

*Stressors.* This section should include information on any significant or traumatic event that has recently occurred which may be related to the behaviors causing concern. Events such as a death in the family, divorce or remarriage, serious accidents or illness, parent's loss of a job, or some other sources of stress have implications for intervention decisions.

This set of assessment data is primarily concerned with determining the extent to which the problems perceived appear to be related to specific situations, or are pervasive across settings. The findings have direct implications for making decisions regarding interventions. For example, when problems are found to be related to a specific classroom or all academic classes, but are not reported in other areas of the school, home, or community, the interventions may focus on modifying the situation between the student and teacher(s). On the other hand, if problems are reported throughout the school, home, and community environments, intervention may require placing the student in a highly specialized program involving community resources. When a student has referred him- or herself and appears to be functioning satisfactorily, he or she may be offered counseling within the school or may be referred to a community agency.

From a more traditional diagnostic perspective, implications can also be drawn from these data which might suggest that those students whose problems are pervasive may be determined to be emotionally disturbed. In contrast, students whose behavior is related to specific situations might be more appropriately regarded as disturbing. Another way of viewing this information is by attempting to determine the extent to which the student is able to discriminate the expectations of different environments, manage the varying sources of stress, and behave in acceptable ways.

*Acute Versus Chronic.* Typically, the information needed for this section is collected simultaneously with the previous information. The task is to determine if the disturbance is acute or chronic by establishing when the problems were initially perceived. For our purpose, acute may be defined as any sudden or recent change in behavior, or the acceleration of behaviors that have been cause for concern for a period up to one year. Chronic may be defined as problems that have caused concern for one year or more. In addition, it is helpful to consider the initial identification of problem behaviors in relation to the normal sequence of events through which children progress at home and school. Specifically, were problems identified before the child entered school, in the primary grades, the intermediate grades, or in junior or senior high school? This

information may indicate how well the student has been able to adjust to transitions. Also, the team will note whether the disturbance was identified following a stressful event, such as those mentioned in the previous section.

It should be emphasized here that a lengthy, detailed social history is not considered necessary, and for that matter, may not be very useful. Learning how long the behavior(s) has been perceived as a problem may have little value beyond indicating how resistant to change it may be. However, knowing whether the behavior is related to a traumatic or transition event may have implications for the kind of support or structure that the student will need. For example, it is common for many students who function successfully in elementary school to begin demonstrating difficulties in junior high school. For these students, their response to the change in school structure may have clear implications for intervention plans.

## Observational Measures

The information collected in this portion of the assessment is a clear and precise description of behaviors that are viewed as inappropriate or maladaptive. It is helpful to conceptualize these behaviors in terms of excesses (those that should decrease or be eliminated) and deficits (those that need to be added or increased). The observable problem behaviors can be listed and described on measures of frequency, duration, or latency. In addition, discrepancy measures and antecedent and consequent events provide valuable observation data.

## Frequency Measures

Frequency measures are used most often and apply to most disturbing behaviors. Frequency measures are recorded in rates per some unit of time ranging from minutes to weeks, depending on the behavior being recorded. For example, fighting or tardiness would be best measured in rates per week or month, while class disruptions may be best measured in rates per hour or day.

## Duration Recordings

Duration recordings measure how long specific behaviors last from onset to cessation. For example, how long do tantrums last, how much class time does the student miss because of tardiness or absences, or how quickly does he or she settle down after becoming angry?

## Latency Recordings

Latency recordings measure the amount of time which passes from when

a stimulus is presented until the desired response occurs. For example, when the teacher asks the student to begin an assignment, how long does the student take to begin the task?

## Discrepancy Measures

By themselves the previous measures can be very misleading. The data are much more meaningful when they indicate how discrepant the student's behavior is compared with that of other classmates. It may be an injustice to focus on the disturbing behavior of one student when others in the class are behaving in the same way. Discrepancies are best stated in terms of how likely it is, more or less, that the student will behave differently from classmates. For example, John disrupts the class eight times more often than the other students, takes three times as long to settle down when he gets angry, and twice as long to get started on his assignments.

## Antecedents and Consequences

Two other kinds of data required for observational measures are the antecedent and consequent events. It is important to know what events occur immediately before the disturbing behavior and appear to set it off, what happens after the behavior, and what appears to reinforce it. Collectively, the data from direct observational measures can provide an accurate description of the problem behaviors, indicate the magnitude of the problem, and provide a means of evaluating the success of intervention. The data may be on as few as one or two behaviors, or on a long list of behaviors that are viewed as disturbing.

Each of the previously described kinds of measures can be reported in averages or close approximations when the assessment team is considering changing the student's school placement as an intervention, such as into a special class or special school. However, when the interventions being considered may be implemented in the environment where the problems are occurring, the measures should be as accurate as possible.

## The Identification of Affective, Cognitive, and Behavior Patterns

Traditionally, the process of identifying affective, cognitive, and behavior patterns includes the use of formal psychometric tests or other instruments and interviews by psychologists and/or psychiatrists. This process is what is usually referred to as the "psychological assessment." Within this assessment model, the use of classification labels, such as "adjustment reaction," or "neurotic" or "psychotic" disorders, are not viewed as helpful, but a description of affective and behavioral patterns is useful in anticipating the student's likely response to different interventions. The

data included are from formal and informal projective tests, clinical interviews, rating scales, and observation. Three essential descriptions are needed: affective attributes, interpersonal relationship orientations toward peers and adults, and the most prevalently observed pattern(s) of behavior.

*Formal Psychological Tests.* The usefulness of these instruments to educators for diagnosis and intervention planning is regarded by many as questionable. As discussed previously, there is ample reason not to rely on these tests for diagnostic decision; however, when the response patterns are interpreted in relation to the observations of individuals who know the student well, test results may be helpful by reinforcing observational reports. In a sense, they may add a degree of confidence. On the other hand, when the results are inconsistent with other reports, they may be useful as a stimulus for further questioning and clarification. In either case, the purpose of psychological tests is not to label, but to determine primary affective and cognitive patterns, and whether they are consistent with the observed behavior patterns.

The decision of which, if any, instrument(s) to use will, of course, vary with the age and characteristics of the student. In the view of this writer, tests should be regarded as optional rather than essential.

*Clinical Interviews.* Generally, clinical interviews are done by psychologists, psychiatrists, social workers, or other mental health professionals. Their interpretations of the student's perceptions and response patterns are less influenced by the stresses felt by teachers and parents experiencing day-to-day concerns and frustrations. From this perspective, their contributions to the assessment can help to maintain a more objective focus. Interpretations from clinical interviews provide helpful information in much the same way as projective tests. When the findings are consistent with other sources of data, they may strengthen considerations for specific interventions; when there are differences, the results may stimulate questions for further classification.

*Rating Scales and Checklists.* Of all the instruments and processes used to identify and evaluate children and youth, rating scales and checklists are probably the most frequently used by educators. As with projective tests, a great variety are available, and many have problems associated with them. They can and do provide useful information. Some scales, such as the Quay-Peterson (1967), can be used to describe primary response patterns in addition to how severe the rater perceives the problem to be. Scales and checklists provide the rater's perception of problem behaviors, which can be used to identify specific behavioral objectives for the intervention plan.

The usefulness of information from rating scales can be improved in a variety of ways. Allowing different individuals, including parents, to complete a form independently will indicate how consistently or differently the student's behavior is perceived. Forms jointly completed by a

group of individuals may increase the reliability of the ratings. A third way to improve the information is to repeat the ratings over successive time intervals. However the rating scales are completed, their diagnostic value is in clarifying dominant patterns of behavior.

In this portion of the assessment, the task is to assemble predictable patterns from formal psychological evaluations, rating scales, interpersonal relationships, observed behaviors, and affective descriptions. It can be considered a personality or general tendency assessment. The information is useful for determining the kinds of support and type of structure the student will most likely respond to positively.

## Potential Versus Achievement

Failure on academic tasks is a primary source of stress for youngsters in school. A thorough evaluation of achieved skills and deficits is important, not only for determining specific instructional objectives, but also for assuring an opportunity for success, personal growth, and a sense of well-being. For the purpose of this assessment model, the basic areas of information required are outlined. More detailed information on specific evaluation processes and instruments can be found elsewhere (Gearhart & Willenberg, 1974; Hammill & Bartel, 1975; Wallace & Kauffman, 1978).

*Assessed Potential (I.Q.).* Measures of estimated potential for emotionally disturbed children are often of questionable validity and, in many cases, may have little impact on the final intervention plans. However, these measures can help to answer questions concerning strengths and weaknesses in learning and they provide an indication of whether or not the student's achievement is near what may be reasonably expected. A wide scatter pattern versus an even profile may help to explain consistencies or inconsistencies in performance. Often I.Q. scores are used administratively to determine eligibility for particular programs.

*Achievement.* There are a multitude of standardized and criterion-referenced instruments available to evaluate reading, spelling, and writing achievement. The data collected should include criterion-referenced tests, but grade-equivalent scores may be adequate for program placement decisions. Most children learn to use language adequately, but when there are indications of delays in language development, speech disorders, or any other concerns about receptive or expressive language skills, more formal assessments should be included. In mathematics, three areas of skills should be included: computation, concepts, and application.

Evaluation of academic skills and areas related to achievement in school is a critical component of the assessment process in education settings. The amount of detailed information required at the placement decision level will vary with how highly correlated maladaptive behavior appears to be associated with academic failure. Disturbing behaviors that are

highly associated with learning situations will have much different intervention implications than those that are more pervasive across settings.

## Medical/Physical Evaluations

Medical evaluations are a routine component of the assessment process. The obvious question is, what, if any, medical/physical problems may explain or contribute to the problems of the student? Students who exhibit possible perceptual motor problems should be evaluated to determine if there are impairments or delays in fine or gross motor development which may contribute to the student's stress in school.

A medical/physical evaluation should include information on the student's general health, diet, sleeping habits, physical maturation, physical stress symptoms, and/or chemical use and/or abuse. These data provide a basis for ruling out physical illness or disabilities as causal or contributing factors. It also may rule out the involvement of a physician in intervention planning. Where students are currently receiving medical treatment, such as behavior or mood-altering medication, the effects of the treatment need to be included in the assessment.

## The Perceived Severity of the Problem

The most difficult and subjective task in the assessment process is determining the severity of the problem. Severity is viewed in many different ways. For example, in diagnostic models that define emotional disturbance as a condition within the student, "adjustment disorders" are less severe than "neurotic disorders," which in turn are not as severe as "psychotic disorders." Educational jargon usually describes the degree of disturbance in terms of mild, moderate, and severe. In the behavioral approach, severity is often judged in terms of the frequency of the maladaptive behaviors. From the ecological perspective, severity is viewed as the relative "disturbingness" of the individual's behavior to other people on some scale ranging from "not disturbing" to "very disturbing."

The severity of problem behaviors can be evaluated by constructing a scale of disturbingness in levels of priority. These scales should include references to the effects of the disturbing behavior on peers, teachers, self, and others, and interventions that usually interrupt the problem behavior. The levels of priority can be described in relation to corresponding levels of service on the Cascade model. Because perceptions of disturbing behavior vary, evaluators will ultimately have to define each level of priority for themselves.

A scale of severity corresponding to the levels of service in the Cascade model is described in terms of "priority." The concept of priority is used because severity is a subjective judgment by the rater(s) and indicates a relative need to intervene, not a specific label. The reference to priority

reflects the fact that the values, skills, tolerance levels, responses, and collective needs of individual teachers, schools, school systems, and communities vary considerably. For example, behavior viewed by some as a low priority may be judged by others as a moderate priority. Table 1 presents an example of how the perceived severity of disturbing behavior can be described on a scale in terms of priorities.

By itself, this scale is no more or less useful than any other measure. To make it more useful, each assessment team must operationalize, or systematize, their subjectivity, by identifying and ranking disturbing behaviors and matching the interventions and resources. Because perceptions of disturbingness vary, there can be no "correct" set of criteria. Table 1 can be used as a guide for assessment teams to develop their own criteria

Table 1
Perceived Intensity/Magnitude/Degree

Low Priority:
1. No or minimal stress/disruption to peers
2. No or minimal stress demonstrated by the subject
3. Concern felt, but minimal stress on teacher, may elect to intervene
4. No or minimal stress indicated by other significant adults
   Examples: Incomplete assignments, reluctant participation

Mild Priority:
1. Disrupts and/or stresses peers
2. Frustration or stress reported or demonstrated by subject
3. Interferes with instruction, requires teacher intervention
4. May require intervention by administrator, support staff, and/or parent
   Examples: Skipping classes, clowning

Moderate Priority:
1. Peers complain or otherwise seek adult intervention
2. Clear agitation, frustration, or stress reported or demonstrated by subject
3. Interferes repeatedly or significantly with instruction
4. Requires support staff and administrative intervention
5. Requires notice to parents and assessment referral
   Examples: Escalating truancy, fighting, defiance, or avoidance; some confusion between real and unreal

High Priority:
1. Excessive disruption and/or threatens peers
2. Generalized frustration, alienation, or agitation reported or demonstrated by subject
3. Teacher feels exasperated and/or threatened
4. Requires immediate intervention by administration and "experts"
5. Requires parent intervention
6. May require intervention of other authorities, e.g., police, child protection.
   Examples: Persistent disruption, assault, pervasive inappropriate responses

Urgent Priority:
1. Extreme stress or disruption in any or all environments
2. Disturbance escalating beyond interventions available; requires continuous "expert" intervention.
   Examples: Life threatening to self or others, chemical dependency, runaway, confuses real and unreal

for levels of priority. Note that at each priority level there is a measure of disturbance as perceived by peers, the student, the teacher, other significant adults, and a measure of the intervention required to interrupt the disturbing behaviors. Also, there are examples of behaviors that may reflect the relative degree of disturbingness. The priority increases as the degree of stress felt by one or more persons increases together with the amount and kind(s) of intervention required to interrupt the disturbance.

Further description of each level of priority is accomplished by combining key elements of the various sections of the assessment data in columns and developing corresponding scales. Table 2 is an example of how frequency, intensity, multiple problems, and chronicity might be scaled and compared. Viewed separately, each column of the "Sample Assessment Rating Scale" provides a different way of determining the priority and probable level of intervention for disturbing behaviors.

The "Frequency" column clearly suggests that the more often the disturbing behavior occurs, the higher the priority. For example, disruptive behavior that occurs once a day or less may be cause for concern for a teacher, but rates of once, twice, or more an *hour* almost certainly will

Table 2
Sample Assessment Ratings Scale

| Exigency | Frequency | Intensity | Multiple | Duration |
|---|---|---|---|---|
| Low Priority (1) | Rate per day: 1 or less<br><br>(Reverse scale for deficits) | Minimal stress/ disruption to self, peers, or teacher | Dysfunction limited to one primary concern, e.g., task avoidance | 0 to 1½ months |
| Mild Priority (2) | Rate per day: 1 - 3 | Stress/ disruption requires teacher intervention | Dysfunction includes two or three primary concerns | 1½ to 3 months |
| Moderate Priority (3) | Rate per day: 3 - 5<br>Rate per hour: 1 - 2 | Stress/ disruption requires teacher, support staff, and parent intervention | Dysfunction includes task and peer or adult relationship | 3 to 9 months |
| High Priority (4) | Rate per day: 5 - 7<br>Rate per hour: 2 - 4 | Stress/ disruption requires "expert" intervention | Success limited to special or structured program | 9 to 12 months |
| Urgent Priority (5) | Rate per day: 7 or more<br>Rate per hour: 4 or more | Stress/ disruption requires removal from regular class | Few or no areas of successful functioning | 12 or more months |

require some intervention. Other behaviors, however, such as fighting, may occur infrequently, but because of the stress they produce, result in higher priority rankings under "Intensity."

The "Duration" column indicates the persistence of the problems. Priority increases with chronicity. Similar scale columns can be developed to rank the personality/behavior patterns, academic skill deficits, medical/physical disabilities, and other information collected. The scales are structured, subjective guides for the assessment team to begin to form conclusions about an appropriate level of intervention.

Each student will present a different pattern on the scales and specific problems may have different priority rankings that will have to be weighed to determine a level of intervention. For example, Bill fights once or twice a month (low frequency), producing much stress (high intensity) for the past three months (mild duration), with no other significant school or home problems (low multiple). Or, John gets out of his seat two or three times per hour, talks out of turn, teases other students, finishes few assignments, has few friends, is a discipline problem at home, and has been presenting problem behavior for two years (high-frequency, moderate-intensity, moderate-multiple, and urgent chronicity). Many other variations can be described, but obviously scaling subsets of descriptive data alone does not provide a clear link to an appropriate level of intervention. A prescriptive link is formed when this information is combined with an evaluation of the student's response to interventions that have been attempted.

In the model proposed here, the degree of severity is determined by the interactions between the student and the environment, requiring a combination of data describing the "disturbingness" of the student's behaviors and the levels of interventions necessary to maintain and build acceptable behaviors. These data, together with the information on pervasiveness, history, specific problem behaviors, and behavior patterns, provide the structure for determining an appropriate intervention at the least restrictive level.

## Response to Interventions

The previous sections have focused on the student's perceptions of self and other's perceptions of the student, factors that may contribute to the disturbing behavior, and the severity of that behavior. This component parallels the initial identification section, but focuses on the specific interventions that have been attempted, for how long, and with what outcomes. The information should include school, home, and community efforts to intervene, as well as the student's own efforts.

*At School.* Within the school environment there are a wide variety of interventions that may be used, and are often tried, in order to change student behavior. The assessment should include data on how the stu-

dent has responded to each intervention or combination of interventions tried.

Within the regular classroom some interventions include: consultation with the teacher; modifying the classroom environment; modifying or individualizing instruction; notes, calls, or conferences with parents; contingent praise or attention; special privileges, jobs, or events; enlistment of aid from peers; incentive systems, including charting, points, or contracts; time out; detention; and referral to the office. With support staff, interventions include: counseling, either individual and/or group; monitoring and reinforcement; parent contacts; and health screening.

Other in-school alternative interventions include: Title I basic skills classes; "pocket school" programs (school within a school); support groups such as Alateen or cultural enrichment groups for minority students; work release; and special project programs.

Administrative interventions include: "talking to"; suspension; parent conferences; room, teacher, school changes; modified day; file charges with court, e.g., for truancy; and reinforcement and encouragement. Special education interventions already tried may include: observation, assessment, and consultation; reinforcement and monitoring; resource room (one to three hours per day); and special classes.

*At Home.* Interventions at home focus on what parents, siblings, and other relatives are using or have tried, in an attempt to interrupt disturbing behavior and on how the student responds. Parents' interventions may include: supportive time—encouragement, praise, recreation, and personal attention; structured time for work, play, eating, and sleeping; definition of clear limits; contingent privileges or allowance; and punishments (e.g., grounding, spanking). Siblings and other relatives often provide assistance by providing supervision, personal support, and/or recreational activities. In some instances they may be acting as guardians.

*In the Community.* Included here are the supports that have been provided to the parents, as well as to the student. The assessment should include reports on any community-related interventions that have been tried. Public agency services include those by the child protection or family services divisions of the welfare department, mental health centers, and the police or court system. Private agency services include those of medical doctors, therapists, organizations such as Big Brother/Sister programs, and parent advisory organizations. Recreational programs such as YMCA/YWCA or the Boys/Girls Clubs that have provided support should also be included in the reports. The family's religious group may also be a resource. Finally, any history of residential interventions, including group or foster homes, hospitals, or treatment centers should be reported.

*Self-Interventions.* Efforts by the student him- or herself to intervene in a disturbing situation may often be overlooked by evaluators. In many instances the student, if mature enough, will attempt to change his or her

own behavior and/or relationships with others. In circumstances where the disturbingness of the student is regarded by others as a low or mild priority, the student may have actually attempted more interventions than the adults around him or her. This may be particularly true when the student is experiencing more stress than others perceive. Many students seek help when their own efforts have been ineffective. The student should be asked what interventions have been tried. Some possibilities could include talking with teachers, counselors, and parents; avoiding conflict situations; ignoring provoking behavior of others; trying to relax, counting to ten; working harder; and asking for help.

*Evaluation of Responses.* The process for evaluating student responses to interventions is similar to the one used to determine the severity of the problem. The assessment team must organize the interventions into categories and develop a scale that corresponds to both levels of priority (low to urgent) and to the Cascade model. A structure for determining an appropriate level of service is provided by matching the student to an intervention level at which acceptable behavior is maintained and disturbing behavior is interrupted. Table 3 is an example of how behavioral, instrumental, environmental, and temporal elements of interventions in school might be organized in scale columns. Other columns might be constructed for "home," "community," and "self." Note in the "behavioral" column that as the scale increases from low to urgent priority, the interventions become more intrusive. The "Instrumental" column reflects increasingly more specialized planning, evaluating, and documenting processes. The "Environmental" column describes where effective intervention occurs, and the "Time" column reflects how much intervention time is necessary each day.

In addition to developing operational scales, a system that can be used to evaluate the effectiveness of low, mild, moderate, high, and urgent levels of intervention must be included. Table 4 is an example of how the student's response to interventions can be rather simply assessed and compared among environments. The criteria for outcomes are described in terms of "none," "minimal," "temporary," and "successful," and can be applied to each level of intervention employed.

Using the scales and the "Summary of Responses to Levels of Intervention," the assessment team can assemble a detailed picture of how effective different treatments are, or may be, in different settings. For example, the findings may show that low or mild level interventions are not effective in regular classrooms, but are successful in a resource or Title 1 room. Or, they might show that lower level interventions are successful in the regular classroom only when they are combined with higher level interventions by support staff, administrators, and parents. The areas that are crossed out on the table indicate that urgent interventions are not available to regular classrooms and mild interventions are an individual, not a community, response to disturbing behaviors. Whatever the pattern, these data, combined with the assessed priority and descriptive informa-

Table 3
Sample Levels of Intervention

| | Behavioral | Instrumental | Environmental | Time |
|---|---|---|---|---|
| Low (I) | "A look," nod, proximity reminder, reprimand, conference, redirect, ignore, praise, model | Note, written report, grades | Regular class change seating | Minimal |
| Mild (II) | Scold, refer to office, withhold privilege, parent conference, contingent attention, detention, monitoring | Reports, charts points, modified materials | Regular class, modified room arrangement, changed class or schedule | Requires repetition and monitoring |
| Moderate (III) | Planned counseling, suspension, parent conference, role play, inclass time out | IEP, comprehensive assessment, reports, charts, individualized materials, contracts | Special education class(es) Title I, other structure | One to three hours daily |
| High (IV) | Formal suspension, out of class time outs, daily counseling: individual or groups | IEP, individualized curriculum, daily behavior monitoring and feedback, full token economy program, court order | Modified day, transfer to different school, primary placement in special ed, community agency | Minimum of four hours daily |
| Urgent (V, VI) | Physical restraint, seclusion time out, medication | IEP, formal criteria for return to mainstream | Restricted movement special school, residential, hospital | 5 to 24 24 hours |

Table 4
Summary of Responses to Levels of Intervention

| Level | Outcome | Regular Class | Special Class | Support Staff | Home | Community | Duration |
|---|---|---|---|---|---|---|---|
| Low | None | | | | | | |
| | Minimal | | | | | | |
| | Temporary | | | | | | |
| | Successful | | | | | | |
| Mild | None | | | | | | |
| | Minimal | | | | | | |
| | Temporary | | | | | | |
| | Successful | | | | | | |
| Moderate | None | | | | | | |
| | Minimal | | | | | | |
| | Temporary | | | | | | |
| | Successful | | | | | | |
| High | None | | | | | | |
| | Minimal | | | | | | |
| | Temporary | | | | | | |
| | Successful | | | | | | |
| Urgent | None | | | | | | |
| | Minimal | | | | | | |
| | Temporary | | | | | | |
| | Successful | | | | | | |

Duration = Number of weeks/months the intervention was tried.
None = No observed change in behavior or increase in disturbingness.
Minimal = Interrupts inappropriate behavior but must be repeated daily or more frequently to suppress inappropriate behavior and maintain desired behavior.
Temporary = Desired behavior is maintained only with periodic interventions (e.g., once a week).
Successful = Desired behavior is sustained at least six weeks without further intervention.

tion, provide an assessment structure with a direct link to an educational level of service, suggesting specific intervention procedures.

## Positive Student Attributes

Intervention plans must be based on areas of strengths as well as deficits. This section describes skills and characteristics which are viewed by the student and others as capabilities or positive attributes. Factors to consider include academic, personal, interpersonal, physical, and preferred activities.

*Academics.* What competencies does the student have in basic skills classes or subjects of special interest? Also, what communication skills, perceptual-motor development, or prevocational or vocational skills does the student demonstrate?

*Personal.* What positive personal attributes are used to describe the student by peers, teachers, support staff, members of the community, and parents? How does the student describe him- or herself?

*Interpersonal.* What is described as positive in relationships with peers and adults? Are there special relationships within a particular age or type of group?

*Physical.* Is health, maturation, and/or appearance an asset? Does the student have any special abilities?

*Preferences.* Answers to these questions may suggest reinforcers that can be included in the intervention plan. What classes or subjects, hobbies, or activities does the student enjoy? What does he or she do for entertainment when alone and when with others? What does the student need or want?

It is sometimes difficult for teachers and/or parents to think of positive attributes when they feel frustrated or upset about disturbing behavior. The student may also have difficulty, particularly if he or she has received extensive feedback about his or her disturbing behaviors. But it is important to clarify strengths and interests as much as possible in order to develop an intervention plan with a positive focus.

## The Environment

The significance of the environment as a consideration in the assessment process was succintly stated in a Tom Wilson "Ziggy" cartoon, in which Ziggy, standing before the principal and looking up, says, "Maybe I'm not an underachiever. Maybe you are an overexpecter." Often there may be little that can be done to change environments, but assessment teams must consider the environment's influence on the student's behavior and

the intervention options that are available. Factors to include are school (district), community, and family characteristics.

The climate of the school is one way of describing the information that is helpful here. In what ways does the school contribute to meeting the safety, security, success, and belonging needs of the student, or to the disturbing behaviors? What is the student-teacher ratio? Are adequate support staff resources available? Are the expectations in the school rigid or accomodative? Are the discipline and behavior manangement policies clear and consistently followed? What are the advantages and limitations of the physical plant?

It is most important to consider teacher characteristics. Are they experienced or inexperienced? Are they flexible or rigid? Are they student-or subject-matter oriented? Are they confident or insecure, sensitive or demanding, open or closed? Are they well trained?

*Family Characteristics.* Parents or families are often blamed for the problems of their children. The fairness of this can be argued, but because the home is the student's primary environment, information about the family is necessary. Are the natural parents present, separated, or divorced? Has a parent died? Is there a stepparent? How many children are in the family? Are they living in the home or nearby? Does the family's ethnic origin include culturally different values, behavior, or language? What is the socioeconomic level of the family? What stressors is the family facing, such as need for job, housing, or health care? Is the family stable or does it move frequently? How much education do the parents have? Are the parents loving, indifferent, or rejecting toward the student? Do the parents value education and are they supportive or hostile toward the school?

*Community Characteristics.* The impact of the community may be subtle or apparent, but in some way the community will influence perceptions and have implications for interventions. It is an urban, suburban, or rural community? Is it conservative or liberal? Is it generally a low, moderate, or high socioeconomic community? Does it have a limited or a full range of human services available?

The ecological view focuses on the significance of the environment. Clearly, behavior that is accepted and even encouraged in one environment may be disturbing and rejected in another. Expectations, tolerance levels, and support services vary from school to school, home to school, and from one community to another. The assessment team itself, being a part of the environment, will reflect those variations and, therefore, must be cautious about applying labels such as emotionally disturbed to children and youth. It must be more concerned with matching services to students' needs.

## Assessment Summary

The preceding sections discussed the assessment variables that should be considered for placement and intervention decisions. When this assessment information is collected, the evaluators will have established a profile of the student which will include: how situational or pervasive the disturbing behaviors are; how long they have been perceived as a problem; how severe the problems are perceived to be; and what interventions have been tried with what outcomes. In addition, the team will have collected information on academic achievement, medical history, the student's strengths and preferences; and significant characteristics of the environment.

A summary of the assessment data can then be organized on a grid form, such as in Table 5, where elements of the data can be ranked in terms of priority and compared for patterns of consistency or variance. Note that across the top of the figure, all significant elements of the ecosystem are included: self, school, home, and community. Drawing from the data on severity and response to interventions, the evaluation team can determine a priority level for each element of the ecosystem in relation to the identified disturbing behaviors, the response and relationship patterns, and the outcomes of the interventions that have been attempted. At the bottom of each column, an exigency, or overall priority level can be determined, which will reflect the team's judgment of the severity of disturbingness within each element of the ecosystem.

The first column indicates the student's level of distress in the existing situation. Priority ratings within the school include the degree of disturbingness to peers, teachers, support staff, and administrators, and a comparison of behavior in regular classrooms with other school environments. Ratings of the home environment will include the student's relationship with siblings and parents, responsibilities such as routine household chores and meeting parent expectations, and the team's judgment of the degree of whole family dysfunction. Community ratings will consider the student's relationships with peers, authority figures, and other agencies.

Summarizing the data in the form of priority ratings on this grid provides a three-dimensional perspective on the disturbingness of the student's behavior. It will show *where* the behavior is a problem, *how* disturbing it is, and it will suggest *what* level of intervention would be appropriate. The use of priority ratings on the grid allows for consideration of the spectrum of problems from the ordinary to the most disturbing, and from the highly situational to the most pervasive. By examining the priority patterns, the evaluators can differentially determine where interventions are appropriate and what level of special education service to provide.

The conversion from priority to a level of special education service is straightforward. Recalling the Cascade model, low priority = consultation; mild priority = instructional changes or supplementary services;

Table 5
Assessment Summary

| | Self | School | | | | | Home | | | | Community | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Peers | Teachers | SS | Environment Reg | Other | Sib | Parent | Resp | Fam Dys | Peers | Authority | Agency |
| **Behavior/Stress** | | | | | | | | | | | | | |
| Frequency | | | | | | | | | | | | | |
| Intensity | | | | | | | | | | | | | |
| Multiple | | | | | | | | | | | | | |
| Duration | | | | | | | | | | | | | |
| **Response Pattern/Relationship** | | | | | | | | | | | | | |
| Aggression | | | | | | | | | | | | | |
| Pass Aggress | | | | | | | | | | | | | |
| Avoidance | | | | | | | | | | | | | |
| Escape | | | | | | | | | | | | | |
| Immature | | | | | | | | | | | | | |
| Dependent | | | | | | | | | | | | | |
| **Response to Levels of Intervention** | | | | | | | | | | | | | |
| Behavioral | | | | | | | | | | | | | |
| Program | | | | | | | | | | | | | |
| **Exigency** | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |

Stressors:

Reinforcers:

Inhibitors:

Competencies:

Specific Problem Behaviors:

Level of Service Indicated:

0 = No Problem; 1 = Low Priority; 2 = Mild Priority; 3 = Moderate Priority; 4 = High Priority; 5 = Urgent Priority



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moderate priority = one to three hours per day in the resource room; high priority = special class with some opportunity for mainstream experiences; and urgent priority = special school or residential program.

The assessment summary form also includes brief references to sources of stress which appear to contribute to the disturbing behavior, activities, or items which are reinforcers for the student, inhibitors, student competencies, and a list of target behaviors. Collectively, all of the data on the summary form will provide for a prescriptive evaluation with objectives for specific behaviors, specific interventions, and a level of special education service in the least restrictive environment.

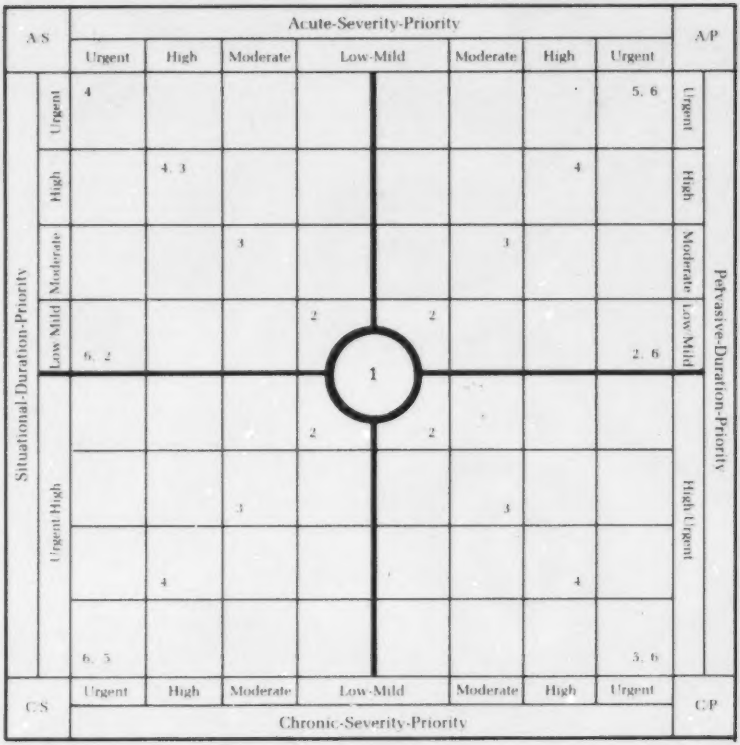
## A Conceptual Model

The preceding sections reviewed assessment variables for differential evaluation of disturbing student behavior. This concluding portion presents a conceptual model for organizing or operationalizing assessment data to make placement decisions in special education programs. It is assumed that all disturbing behaviors are perceived by the evaluators on some continuum, and that they can be rationally evaluated on a scale of priority without the need for traditional diagnostic classifications. Further, the task of assessment teams is to develop prescriptive differential evaluation systems that place students in appropriate, least restrictive levels of service, as well as provide specific treatments. Differential placement assumes that evaluators must make recommendations based on a continuum of services as presented in the Cascade model.

The key variables of the placement model are: situational versus pervasive behaviors; acute versus chronic histories; and the severity priority of the disturbing behavior. Table 6 is an illustration of how the variables are organized for differential placement decisions. In the model, disturbing behavior is identified with one of four quadrants, based on its duration and pervasiveness. Within a quadrant the behavior(s) is further identified with a cell that describes its severity and duration priority.

The quadrants are "acute-situational," "acute-pervasive," "chronic-situational," and "chronic-pervasive." The process for deciding which quadrant describes the student is simple. First, determine how long the behavior has been perceived as a problem. If it has been less than one year, the top, or "acute," half of the grid will be used. The bottom, or "chronic," half is used for problems persisting for more than one year. Second, determine if the disturbing behavior is primarily situational or pervasive. This can be accomplished by examining the "Assessment Summary" and determining whether the behavior is associated with an identifiable situation or type of situation, or if it is consistent across environments. If the disturbing behavior is associated with a specific setting, then the left, or "situational," half of the grid will be used. If it is consistent across environments, the "pervasive," or right, half will be used. It

Table 6
A Model for Planning Special Education
Service Levels for Students with Disturbing Behavior




should be noted here that the disturbing behavior may be consistent across one environmental setting, such as the school, but may not be perceived as a problem at home or in the community. In this instance, the disturbing behavior is regarded as primarily situational. The result of these two steps will place the student in one of the four quadrants.

Once the appropriate quadrant has been identified, the evaluators must determine which cell most accurately describes the student. The two dimensions within each quadrant are, "severity priority" and "duration priority." The severity priority is derived from the combination of the "intensity scales" and "response to intervention scales" discussed in the preceding sections. The duration priority increases with the amount of time the behavior has persisted, and is further defined.

Before discussing each of the quadrants in more detail, the reader should note in Table 6 that at the center of the model is a circle that represents the mainstream educational program. As you proceed away from the center in any quadrant, the priority increases in severity, duration, or both. The numbers in the cells refer to levels of special education services where: 1 = consultation; 2 = supplementary resources; 3 = resource room; 4 = special class; 5 = special school; and 6 = residential school. Tables 7, 8, 9, and 10 provide a more detailed description of the criteria for each of the cells in the quadrants. Remember that the criteria are presented as a guide, as examples from the author's perception and experience. Each team must define criteria to match its own assessment context, and service levels that are identified with each of the cells should be viewed as probable, least restrictive levels of intervention.

Table 7 shows sample criteria for placement decisions in the acute-situational quadrant. Students in this quadrant have been identified for one

Table 7
Acute/Situational Sample Placement Criteria

Acute

| Situational | Urgent | High | Moderate | Low/Mild | |
|---|---|---|---|---|---|
| Urgent | 4 | 4 | 3 | 2, 1 | Up to one year |
| High | 4 | 4, 3 | 3 | 2, 1 | Six to nine months; increasing deterioration of acceptable behavior |
| Moderate | 3 | 3 | 3 | 2, 1 | 6 to 24 weeks. |
| Low/Mild | 6 / 2 | 2 | 2 | 2 / 1 | Abrupt onset; unanticipated or accelerated increase in maladaptive behavior; zero to six weeks. |
| | Life threat, extreme response to trauma / Has success in one regular class in relations with adults or peers. | Failing most areas in school, responds positively to support and success structure | Response to type of person (authority) or situation (passive learning, low structure generally limited to school) | Response to specific identifiable person(s), place, or source of stress. | |

year or less and their disturbing behavior is primarily associated with an identified situation or setting. The kinds of behavior may range from getting failing grades to assault, or from skipping class to vandalism. Note that in general, the highest level of placement is a special class. However, an extreme or rapidly accelerating disturbance, such as an assault or suicide attempt, may require a residential placement.

Table 8 shows sample criteria for placement decisions in the acute-pervasive quadrant. By comparison to the preceding quadrant, the disturbing behaviors here are a concern in at least two environments, that is, school and home. Because of the consistency of the disturbing behavior, special schools or residential programs are more probable interventions for "high" and "urgent" priority problems, particularly as the duration increases, in order to provide comprehensive and consistent intervention programs.

Table 8
Acute/Pervasive Sample Placement Criteria

Acute

| | Low Mild | Moderate | High | Urgent | |
|---|---|---|---|---|---|
| Up to one year | 1, 2 | 3 | 4, 5 | 5, 6 | Urgent |
| Six to nine months, increasing deterioration of acceptable behavior | 1, 2 | 3 | 4 | 4, 5, 6 | High |
| 6 to 24 weeks | 1, 2 | 3 | 4 | 5 | Moderate |
| Abrupt onset, unanticipated, or accelerated increase in maladaptive behavior, zero to six weeks | 2 / 1 | 2 | 2 | 2, 6 | Low Mild |
| | Disturbing behavior in response to times, places, or persons, evoking high stress in failure | Disturbing behavior throughout school and some at home. Responds positively to selected persons, structure. | General pattern of disturbing behavior. Demonstrates positive response only to supportive structure, person. | Disturbing behavior generalized in time, place and to persons. Indiscriminate response to trauma. | |

Pervasive

Tables 9 and 10 present sample placement criteria for disturbing behavior that has persisted for a long period of time. Because of the history of the behavior, the duration-priority is considered high to urgent. Placement decisions are based more on the severity priority. As above, the important difference between these two quadrants is criteria that refers to behavior in association with situations or across settings. It is tempting here to classify students in these two quadrants as those who are disturbing (chronic-situational) and those who are emotionally disturbed (chronic-pervasive). In a practical sense, the former group is most likely to be represented by students who have traditionally been regarded as "conduct disordered" or "socially maladjusted." Their behavior pattern shows that they do respond selectively to different environments and are unlikely to have a diagnosis of "thought disorder." Often these are the students who are merely tolerated, or who were repeatedly punished while very young, or who will be placed in court-supervised programs when they are older.

Table 9
Chronic/Situational Sample Placement Criteria

| Priority | Significant problems in school, home and community. Resists, defies external relations. | Failing in most areas of school. Same problems out of school. Acceptable behavior in positive supportive structure. | Persistent disturbing behavior in various times, places but satisfactory under specific structure, persons. | Disturbing behavior repeated in specific school structure, temporarily suppressed by intervention. | |
|---|---|---|---|---|---|
| High | 5 | 4 | 3 | 2 | 1 One or more years "good weeks, bad weeks." |
| | 5 | 4 | 3 | 2, 1 | One or more years behavior patterns generally predictable. |
| | 5 | 4 | 3 | 2, 1 | Two or more years. |
| Urgent | 5, 6 | 5, 4 | 3 | 2, 1 | At least two years, escalating. |
| | Urgent | High | Moderate | Low/Mild | |

Priority

Chronic

Table 10
Chronic/Pervasive Sample Placement Criteria

| | Disturbing behavior is in response to time, place, person evoking high stress or failure. | Disturbing throughout most areas of school, some home. Responds positively to selected persons, structure. | General pattern of disturbing behavior, responds positively only to supportive structure person. | Disturbing behavior generalized in time, place and to persons, indiscriminate. | Pervasive Priority |
|---|---|---|---|---|---|
| One or more years with intervals of weeks or months of latency. "Good weeks", "Bad weeks." | 1 2 | 3 | 4 | 5, 6 | High |
| One or more years, behavior generally predictable. | 1, 2 | 3 | 4 | 5, 6 | |
| Two or more years. | 1, 2 | 3 | 4 | 5, 6 | |
| At least two years, escalating. | 1, 2 | 3 | 4 | 5, 6 | Urgent |
| | Low/Mild | Moderate | High | Urgent | |

Chronic Priority

The chronic-pervasive group, on the other hand, is most likely to be represented by students traditionally diagnosed as "personality-disordered," including the "psychotic." These students have typically been referred to treatment programs. However tempting this kind of classification is, we are reminded that there is no diagnostic purity and that attempts at classifying the quadrants are more of a retreat to traditional labeling than prescriptive assessment.

In summary, it is important to state that while this model has not been implemented on a district-wide basis anywhere, it is being used to place students differentially in special school programs for the emotionally disturbed in Minneapolis, Minnesota. Minneapolis Public Schools do provide a full range of service levels from preschool through high school. Regular education programs are responsible for identifying the needs of students and for attempting the intervention options that are possible

within mainstream buildings. When the "student support team" concludes that it is unable to serve the student successfully, a referral is made to a central evaluation committee. The data reviewed by that committee include all of the kinds of information discussed in the previous sections and placement decisions are based on criteria comparable to those described here. It is true that, for administrative purposes, students who are placed in special classes, special schools, or residential programs are labeled emotionally disturbed, but in assessment conferences the label serves more as a description of the priority for service, rather than a classification of the student.

## Conclusion

The assessment and placement of students with disturbing behaviors in special education programs is, at best, imprecise. Judgments are influenced by the values, tolerance levels, biases, definitions, and perceptions of the evaluators, and by the resources and values of the community. As special educators, we are responsible for providing programs that meet students' needs in the least intrusive way possible. Our ongoing challenge has been to develop instruments and models which will enable us to match more closely the needs of students and environments. The model presented in this paper represents an "ecobehavioral" approach. The model is based on the assumption that judgment will always be part of the assessment process, but also that the subjectivity of evaluators can be organized in a way that more objectively links disturbing behaviors to appropriate levels, as well as to specific interventions.

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# Part 2: Planning Public School Programs

# Perspectives on the Development of Educational Programs for the Emotionally Disturbed

Norris G. Haring

Among the professional disciplines that provide services to handicapped children, education has pioneered the effort to serve the emotionally disturbed. Educators have produced their most comprehensive and effective intervention and management programs when they have worked together with professionals from the field of special education. Looking back, one can identify those psychological bases from which educators have devised specific strategies and interventions within direct service settings. The actual history of education for the emotionally disturbed, however, can hardly be seen as an incremental series of progressively better educational practices. Rather, in sorting through the primary and secondary reports of educational practices in documents and textbooks, one finds that the history of the education of these individuals (up to circa 1950) resembles a dance step—one step forward, two steps back. Only as educators realized the effectiveness of applying behavioral principles to the intervention and education of children and youth with emotional disorders have educational approaches become more systematic.

## Developments up to 1950

Before the 1950s, education of children with behavior disorders was considered incidental to their psychological, psychiatric, and medical treat-

ment. Since the middle of this century a number of approaches have been developed for educating these children; the groundwork for these strategies, however, was established in the nineteenth century. Like most developments in special education for any category of the handicapped, these strategies have their theoretical and procedural beginnings in the intense training program developed by Jean Itard, a nineteenth century French physician. Itard developed his procedures through attempts to teach a wild boy, named Victor, found in the Canne forest near Aveyron, France, who apparently had been without human contact from early childhood. The boy was profoundly retarded and exhibited many behaviors seen in children with severe behavior disorders. Itard's assumptions for treatment were based on the notion that Victor had not learned to use language or to behave appropriately because of inadequate stimulation. This failure had in turn retarded the development of the central nervous system. While his notions were simplistic, the systematic procedures and instructional tasks that Itard designed nearly 200 years ago to increase appropriate social and language behaviors still serve as a foundation for the procedures used today with the retarded and the behaviorally disordered. In the nineteenth century Edward Sequin recognized the implications of Itard's procedures and Maria Montessori applied his techniques to the teaching of the retarded. While education or training was becoming a primary goal for retarded individuals, educating the emotionally disturbed was considered secondary to the main considerations of their diagnosis, identification of etiology, and treatment.

During much of the nineteenth century, emotionally disturbed children, along with adults, were referred to as being insane, and their treatment was based on superstitious and bizarre assumptions. Education gained some acceptance as a treatment despite these assumptions, however, and by the middle of the century, schools had been established in "insane asylums" and specific teaching methods had been developed (Kauffman, 1976).

Educational programs that included such methods as individual assessment, highly structured environments, and functional curricula, as well as self-help training in daily life skills began to be developed within asylums. This represented an advancement that came about as a result of humanistic educators (Brigham, 1845, 1847, 1848; Howe, 1851; Ray, 1846; Sequin, 1866). These programs were, however, provided primarily for the more severely mentally retarded residents, not for the behaviorally disturbed (Brigham, 1848; Sequin, 1866). However, educational curricula that included moral treatment were believed to be constructive forces for mental health (Bokoven, 1956). Only sketchy records can be found describing further development of educational intervention with the behaviorally disturbed during the nineteenth century (Kanner, 1957; Rubenstein, 1948). Not until a century later were the methods developed for the retarded to become a major influence on the education of children with severe behavior disorders.

By the end of the nineteenth century, a general change occurred in the

approach to the treatment of the emotionally disturbed. Psychiatry emerged as a treatment discipline, and various psychodynamic theories were used as the basis for management strategies. The writings of the final decade or so reveal a reduced interest in teaching or training and an increased application of psychiatric therapy (Harms, 1967); however, "Psychiatry became increasingly engrossed in varieties of psychodynamic theory, and therapeutic action on behalf of patients gave way often to interest in diagnosis and classification" (Kauffman, 1981, p. 44).

## The Mental Hygiene Movement and the Focus on Child Development

The mental hygiene movement, which began in 1909, had a lasting influence on the conceptualization of the etiology and treatment of emotional disturbance. This influence began with the establishment of the National Committee for Mental Hygiene by layman Clifford Beers, psychiatrist Adolf Meyer, and psychologist William James (Berkowitz & Rothman, 1967). As a result of the activities of this organization, child guidance clinics, supported by state and local funds, were organized. Many of these clinics associated themselves with already existing adult-centered clinics.

During the 1920s mental hygiene programs were developed in the public schools, and efforts by schools to identify children with emotional problems focused on the need for cooperation between the schools and local child guidance clinics. Many of the clinics, however, had based their theory of treatment on traditional Freudian orientations and had adopted a psychodynamic approach that was incompatible with the more direct approach of the educators. Problems in communication and management arose between the public schools and community child guidance clinics, and teachers had difficulty interpreting and applying diagnoses and recommendations made by the guidance clinic personnel.

A parallel influence was the emergence of the field of child development. The study of the normative development of infants and children began at about the same time as the mental hygiene movement. The respect that Freudian psychology engendered for the importance of childhood experiences contributed to the study of child development and substantiated the predominant role of children's affects and emotions in their overall growth and behavioral development. In 1911 Arnold Gesell founded the Clinic for Child Development at Yale University. Gesell and his associate, Ilg, developed a scale for measuring children's development which involved a systematic comparison of individual children with the "norm." This scale was widely used and established the strategy of normative assessment, later giving rise to the developmental approach. One example of the application of this approach was in the behavior clinics established in 1925 by psychiatrist Dr. Smiley Blanton, director of the Minneapolis

Child Guidance Clinic. These clinics, based in kindergartens, took referrals from teachers, parents, and preschools. In addition to direct intervention with children, they provided counseling to parents and teachers.

Both the child guidance clinics and the developmental approach influenced current special education practices in two major areas. They helped shift the focus from seriously disturbed children to a broader focus that included mildly disturbed children, who represented the majority of disturbed children in the public schools (Lewis, 1974). They also established a multidisciplinary treatment paradigm that often included the home and involved a team of professionals who worked directly with children and their families. Psychologists, psychiatric social workers, visiting teachers, and therapists worked together within the clinics to provide the necessary care. The child guidance clinics, combined with the innovations in research, new teacher training programs, and a shift towards a recognition of the importance of direct intervention in the lives of handicapped individuals, led to the beginnings of educational intervention facilities for the emotionally disturbed.

## The Development of Child Psychiatry

The psychiatric model was based on the traditional conceptualization of emotional or behavior disorders as diseases. As Kazdin (1978) notes, the model might be more accurately described as the "intra-psychic disease" model. This model had been given some substantiation by the discovery that the syphilitic spirochete caused general paresis. The model prevailed in the absence of competing theories of the genesis and treatment of emotional disorders and has served as a basis for the language of psychology; from it come such misleading terms as "symptomatology" and "pathology." The model still influences our current concepts and affects our current educational and intervention practices.

The disease model employs comprehensive medical assessment, including analysis of body fluids and tissues, and electroencephalograms. To the limited extent that remediable causes have been found, this approach has been useful. The model is of limited use, however, in changing maladaptive behavior because not all, or perhaps not even most, maladaptive behavior has a disease or biological basis. Nevertheless, the intrapsychic disease model has had a powerful influence on psychology and education. In psychology, behavior is seen as only a symptom of the underlying disorder; in education, reading or other skill disorders are considered symptoms of underlying brain dysfunction. Even though known organic bases can rarely be established, the intrapsychic disease model continues to be applied.

That Freud adopted the disease model for his psychoanalytic theory is not surprising. He had been trained in physiology and neurology, and during the late 1800s, when he formulated his theories, there was very

little competition from any other model that successfully explained abnormal behavior. By the time the psychology of learning began to evolve in the early 1900s, Freud had set forth most of his ideas, and they had achieved prominence and widespread acceptance. As the science of behavior grew, experimental psychologists did not use their findings to challenge psychoanalytic theory as a treatment approach. Neither research nor a scientific approach to verification was incorporated into psychoanalysis. This lack of a verification procedure, combined with the paradigmatic authority of the disease model, further prevented it from being seriously challenged (Kazdin, 1978).

## Educational Approaches

The first psychiatric hospital for children in the country, Bradley Home in Rhode Island, was opened in 1931. Dr. Lauretta Bender, an authority in the area of childhood schizophrenia, organized the children's ward at Bellevue Psychiatric Hospital in New York City in 1934. She convinced the New York City Board of Education to provide two teachers for special ungraded classes. Pearl Berkowitz and Esther Rothman, the teachers, were trained in the Bellevue School and were instrumental in the development of the "600" schools in the New York City school system for educating disturbed children. These schools were located in regular school buildings, and occasionally, in residential diagnostic centers.

Leo Kanner contributed immeasurably to the development of child psychiatry with his textbook, *Child Psychiatry* (1935). Kanner, in addition to identifying the syndrome of early infantile autism (1943), described the characteristics of various categories of severely and profoundly disturbed children.

The intrapsychic approach to normal behavior failed to generate potent treatment techniques, and dissatisfaction with the model produced a context from which behavior modification developed. The behavioral model of deviance which grew out of psychological research helped to provide an identity for psychology independent of medicine. It provided a new model that enabled researchers to explore areas outside of the old medical model. The theory of development, espoused by behaviorists, provided a concept of deviant behavior and treatment methods for behavior change and management which were substantive alternatives to the intrapsychic disease model and its psychoanalytic treatment method.

## The Development and Influence of Behaviorism

Learning theory was the foundation for behavior modification. Research in conditioning, reflexology, and comparative psychology stimulated the objective study of behavior, and methodological advances made in these areas were applied to the field of behavior intervention in general. The

basis of behaviorism is the emphasis on overt behaviors rather than private experience. John Watson was the first behaviorist of record (1913). He was strongly opposed to the dominant school of psychology and its focus on covert mental processes, not observable behavior. Even though Watson had done some important work in instinctive behavior, he became impressed by the human organism's capacity for learning. He made some rather extreme claims about the potential of the human infant, without factual support at the time. However, many of his claims have subsequently been borne out (Kazdin, 1978).

B. F. Skinner was responsible in large part for establishing the facts that Watson lacked; his work also made possible the development and refinement of behaviorism into a technology. Skinner's work clarified the learning paradigms developed by Pavlov and Thorndike. He distinguished between these two models on the basis of the type of response and the type of conditioning (Skinner, 1937). Responses that were termed respondent are elicited and are often referred to as reflex responses, such as salivation and knee jerk in response to patellar tap. Operant responses are spontaneous, and no eliciting stimuli may be observed. Operant responses may be more difficult to explain immediately because their causes are not detectable without further analysis. Skinner concentrated much of his research on operant conditioning, using an investigative procedure known as the experimental analysis of behavior.

## The Historical Use of Reinforcement Principles

Many systems for consequating desired behavior can be found in early school programs. While it is quite obvious that these applications of reinforcement were not based on the systematic findings of the behavioral laboratory, the functional value of reinforcement has been recognized for many years. Long before the laboratory confirmation of operant conditions, reinforcement principles were used widely. In the earliest examples of teaching, educators used reward systems of one variety or another. An illustration is the use of the pretzel, shaped to represent a child's arms folded in prayer, which was invented in the seventh century A.D., as a reward to children for learning their prayers. Nuts, honey, and figs were given as rewards for learning religious lessons in Europe during the 1100s (Birnbaum, 1962).

Just as rewards have been used throughout history to strengthen desired behavior, punishment has been used in elaborate ways to discourage undesired behavior. Many forms of rewards and punishments were used in education, the military, politics, and business thousands of years before Skinner "discovered" the principles of reinforcement in his laboratory.

The classroom application of applied behavior analysis, conceived and validated by Skinner, was not to emerge for nearly a hundred years, lending credence to a passage in the Biblical book of Ecclesiastes, "There's nothing new under the sun." One of the most systematic applications of

rewards in education was Lancaster's Monitorial System (Lancaster, 1805; Salmon, 1904), developed by Joseph Lancaster (1778-1838) for use in the education of disadvantaged children. Given large numbers of these children, limited facilities, and a lack of personnel, Lancaster developed a peer-teacher monitoring system using academically advanced students from the program (Kaestle, 1973). These student monitors were assigned to a variety of teaching tasks, including taking attendance, distributing and collecting completed work, scoring responses, instructing individual students, and even recommending promotion to the next academic level. Student monitors were assigned to each group of 10-12 students. The goal was advancement to a higher level within the group and eventually to a group at a higher academic level. The Lancaster monitoring system had a fairly elaborate positive reinforcement system. Based on competition, students were rewarded for correct responses. The student in each group with the highest score in all subjects received the highest rank and a ticket of merit. If he or she was surpassed by another student, the ticket had to be exchanged for a merit, stating that the student had achieved, but did not still hold, first place.

Another very early (circa 1880) classroom application of reinforcement was the Excelsior School System (Ulman & Klem, 1975). This system provided merits for such appropriate behaviors as punctuality, orderliness, and studiousness. These rewards, called "excellents" or "perfects," were in the form of tokens. They could be exchanged for a special certificate of outstanding behavior and academic performance. The Excelsior system contained a commercially prepared set of materials, including tokens in different denominations, instructions, certificates, and report-to-parent forms. Thousands of teachers throughout the United States used this system.

## Educational Models

Several models for the education of emotionally disturbed children have been developed over the past two-and-a-half decades. These models draw from psychological theories, but have concentrated upon techniques for educating these students. In some instances, the specific model or approach is derived directly from one school of thought, with strict interpretations of the philosophical base; others, however, are more eclectic in nature, and are broader in their educational application. The first detailed analyses of the various approaches and their theoretical bases were performed by Rhodes and Tracy (1972a, b). Of the models identified by Rhodes and his colleagues, those that have had the most impact on educational service delivery have been the psychoeducational and ecological approaches, and applied behavioral analysis.

### The Psychoeducational Approach

The psychoeducational approach is an eclectic combination of psychody-

namic theory and prescriptive education. Many of its concepts are common to the child guidance movement, but it also includes direct educational intervention. It evolved from within the mental health area as a pragmatic means for understanding behavior disorders. A number of excellent child clinicians developed this approach, based not on research, but on many years of clinical experience.

The most influential of these were William Morse, Fritz Redl, Dave Wineman, and Ruth Newman. Morse and his colleagues were very active in conducting demonstration and professional training programs in the 1950s and early 1960s (e.g., Morse, 1953). Two main management strategies, Redl's Life Space Interview and Morse's Crisis Teacher, characterize the major work of this group. Many of Morse's students, among them Peter Knoblock, Peggy Wood, and Nicholas Long, continued the basic assumptions embraced by psychoeducation, adding their own variations and adaptations.

The basic psychoeducational approach focuses on the cognitive and affective domains and considers the existence of instincts, needs, and drives in disordered behavior. Through treatment, the individual gains insight into and control over his or her maladaptive behavior. The following diagram, adapted from Kauffman (1981, p. 199), illustrates how the process of the psychoeducational approach works to change maladaptive behavior.

| | | | | |
|---|---|---|---|---|
| Instincts Drives Needs | → Cognitive and Affective Problems | → Intervention | → Insight | → Behavior Change |

The psychoeducational model is child centered, as it assumes that the nature of disordered behavior resides in an internal, unconscious state. In contrast, the ecological approach views the problem of emotional disturbance as a result of the interaction among the child and the people and systems in his or her environment.

## The Ecological Approach

The ecological approach is based on the premise that disturbed children require change and intervention in many aspects of their environment—home, school, and community. The most extensive application of ecological techniques has been in the work of Nicholas Hobbs and his program, Project Re-Ed.

Project Re-Ed was a weekday residential program in which the teacher-counselors planned and implemented children's day and evening programs and served as their counselors, recreation planners, and friends. Efforts were made to improve the children's environment by psychiatric social workers who worked with the children's family both during and

after the children's treatment. A liaison teacher maintained contact with the children's school programs in their communities.

The basic elements of the Re-Ed model focus on

1. Educational intervention stressing mental health rather than illness;
2. Teaching rather than treatment;
3. Learning and acquisition of skills rather than personality reorganization;
4. The present and the future rather than the past; and
5. Intervention in the child's total social system and not just educational or intrapsychic processes. (Hobbs, 1965)

Other goals included re-establishing disturbed children's trust in significant adults within their environment and helping children develop a sense of identification and belonging within their communities. Children were also helped to unlearn undesirable behaviors, to learn desirable ones, to set goals, and to gain cognitive control over problem areas.

## Applied Behavior Analysis

Of all the early behaviorists, Skinner, with his work in operant conditioning, has had the greatest influence on education of the emotionally disturbed. He used the principles discovered in his laboratory in practical life situations, and his writings have practical application to the classroom. In addition, many of his students, including Charles Ferster, Ogden Lindsley, and Sidney Bijou, have applied his work to behavioral intervention with seriously emotionally disturbed children and adults. From the late 1950s on, the behavioral approach began to have a major impact on the management philosophy and procedures used in programs for the emotionally disturbed.

Paul Fuller, while a graduate student at the University of Indiana, was among the first to apply operant conditioning to human behavior (1949). He demonstrated considerable behavior changes with a profoundly handicapped young adult. Ogden Lindsley was the first to develop a series of operant conditioning programs applied to human behavior. While on the staff at Harvard University in the early 1950s, Lindsley studied the behavior of psychotics at Metropolitan State Hospital. Extensions of operant techniques in applied settings increased in the late 1950s and early 1960s. An example is the work of Ayllon, who, with Michael (1959), collaborated in a study involving 19 psychotic patients whose behaviors, such as violent acts, psychotic talk, and hoarding, were modified through operant procedures.

In 1962, following a year's study with Skinner, Sidney Bijou established an experimental classroom at the Rainier School in Buckley, Washington. Mentally retarded school age children were given programmed instructional material and were provided reinforcement for work completed cor-

rectly. At about the same time, Montrose Wolf designed a token system, and Donald Baer applied those procedures to modify a number of behaviors in natural settings. Ivar Lovaas, a graduate of the University of Washington, began a series of studies with autistic children at the University of California at Los Angeles.

During this same period, Gerald Patterson, at the University of Oregon, conducted studies with school children who were hyperactive in classroom settings (1965a). One of these studies involved reinforcement of a child's attending behavior with a light as a signal and the advance of a counter on the child's desk. The points on the counter were "cashed in" for pennies. In another study Patterson used social reinforcement (praise) with a seven-year-old child who was experiencing school phobia (1965b). Concomitant to these developments, other psychologists conducted similar applied research with children possessing a variety of behavior disorders in natural settings, including classrooms.

## Operant Conditioning in Special Classrooms

During the time that researchers were refining the methodology, special educators were extending the application of systematic operant procedures and reinforcement in a number of special and regular classrooms. These early attempts by special educators were less sophisticated than those of the psychologists, but the activities they used were more adaptable to natural settings with children. Probably the first application of reinforcement by a special educator in a systematically arranged classroom environment was conducted by the author and Lakin Phillips. In this service-oriented application, two special classrooms in Arlington County, Virginia were established for 15 emotionally disturbed children. One was a primary class (ages seven to nine), the other an intermediate class (ages 9 to 11). These classes provided a highly structured educational setting in which each child was individually programmed with specified work objectives for each day. Minutes of free time were scheduled at certain times each day, depending on work completed correctly (Haring & Phillips, 1962; Phillips & Haring, 1959).

In 1960 the author was appointed Educational Director of the Children's Rehabilitation Unit at the University of Kansas Medical Center and invited Ogden Lindsley to apply his knowledge of operant conditioning and technical skill to education. In the process of arranging behavioral procedures for classroom instruction, Lindsley developed precision teaching, a technique based on the precise measurement of behavior, including pinpointing the behavior to be changed, counting and charting behaviors on the standard behavior chart, and making instructional decisions based on performance data.

Two other special educators who contributed to the development of behavioral technology in special education were Richard Whelan and Vance Hall. Richard Whelan began graduate studies in special education

with the author at the University of Kansas in 1962. Whelan had developed a behaviorally oriented program for emotionally disturbed children while at the Southard School at the Menninger Foundation Clinic. He developed and refined operant procedures to increase their use by teachers in regular and special classrooms. Hall made a substantial contribution to the classroom application of operant techniques. Since moving from the University of Washington to the University of Kansas in 1965, he has been teaching teachers to use reinforcement techniques to modify children's behaviors in regular classrooms settings.

Another application of a behavioral program for the emotionally disturbed was developed by Frank Hewett in 1968. His program, known as the Engineered Classroom, was initiated in the Santa Monica Public Schools and has been widely replicated. Hewett's work involved the developmental sequencing of educational tasks necessary to lead the child from the first stage of the educative process (attention) to the final stage (mastery).

By the 1970s the application of reinforcement principles had spread rapidly throughout school programs for the emotionally disturbed. The procedures, based on hundreds of case studies with school age children, became commonplace in the school, and many teachers skilled in applied behavioral analysis have done meaningful classroom research.

## Other Developments

While the procedures of applied behavior analysis dominate programming for the emotionally disturbed, alternative approaches are proving successful in the management of disordered behavior. Two schools of thought, social learning theory and cognitive behavior modification, are contributing to the knowledge and practice within the field. Both are derived from the larger learning theory model, but have also been influenced by the principles of cognitive psychology. They have broadened the concept of behaviorism by emphasizing cognitive development and the role of cognition in overt behavior. Each approach has associated with it a distinct set of intervention procedures, but both are founded in basic behavioral technology.

### Cognitive Behavior Modification

The cognitive behaviorists' approach to intervention involves their attempt to change overt behavior by altering thoughts, interpretations, assumptions, and strategies of responding (Kazdin, 1978). Cognitive behavior modification evolved from the operant conditioning model. However, those researchers and practitioners who use cognitive processes to change behavior differ significantly from behaviorists. Cognitive beha-

viorists emphasize the person's perception and interpretation of environmental events, and are willing to employ internal, private, implicit, or covert events as intervention techniques. They do not limit intervention to the arrangement or rearrangement of the environment.

The great debates from the early development of learning theory about what learning is, how learning occurs, and what role mediating variables play may be reduced to cognitive versus stimulus-response explanations of learning (Kazdin, 1978; Spence, 1950). The basic role of cognition in learning was first discussed by Tolman (1952), who maintained that the individual learns strategies of responding and perceives general relationships in the environment. Earlier, Thorndike (1935) had written that cognitive processes may facilitate learning but are not essential. Dissatisfaction with the strict operant model resulted in the development of intervention strategies that fall under the rubric of cognitive mediation.

Evidence that individuals can and do learn to control behavior as a result of this process is steadily increasing. Because overt behaviors are not always the essential problem, the individual's thoughts, specifically self-concept and self-evaluations, as well as feelings and verbalizations may become the target for change. Changes in cognition, then, influence behaviors. In human conditioning, researchers have noted that humans seem to form perceptions that complicate the experimental results (Grings, 1965). In a variety of learning experiments researchers have noted that human subjects provide self-instructions that increase cognitive activity. There is little doubt about the importance of thought in many aspects of behavioral research.

Cognitive processes have been used in behavior modification for some time. Wolpe (1958) refers to "thought-stopping," which has been used in behavior therapy. In that intervention the therapist shouts "Stop!" to interrupt the subject's obsessing. The subject repeats "Stop!" to him- or herself to control thoughts.

Lloyd Homme discussed another application of cognitive behaviorism in "Control of Coverants: The Operants of the Mind" (1965). Homme coined the term 'coverant" by combining "covert" with "operant." Coverants are private events—thoughts, images, reflections, and fantasies. According to Homme, controlling coverants need not be impaired by overt responses or consequences. Individuals know best when they experience private events (coverants) that have been selected for change and they can apply consequences. Accordingly, in order to change an overt or covert behavior, individuals select a behavior such as smoking, determine the behavior objective, and provide the reinforcing consequence when the target consequence is reached. Other techniques have been developed by psychologists including Mahoney (1974), Meichenbaum (1977), and Mischel (1973), and include rational-emotive therapy, self-instruction training, cognitive therapy, problem-solving, and self-control.

## Self-Control Techniques

The development of procedures to enhance self-control are of particular interest to educators. In these procedures stimulus control techniques are used to modify a behavior that the client wishes to change or that is socially inappropriate or not controlled by a narrow range of stimuli (e.g., overeating). Behavior is systematically associated with stimuli until it comes under the control of the stimuli. Self-control may be enhanced by self-observation and the self-recording of data on the behavior to be changed.

Self-observation is often successfully supported by self-reinforcement and self-punishment. The individual determines the responses to be reinforced and can reinforce him- or herself at any time. Clients are taught the basic principles of operant conditioning, and an external agent may initially implement the contingencies. Self-reinforcement has been used successfully in elementary classrooms to improve attention and studying and to reduce disruptive behavior (Kazdin, 1975). Self-control may also involve alternate response training, such as replacing anxiety with relaxation.

Opinions vary concerning the effect of external forces on self-control operations, and the design of most self-control studies prevents total exclusion of external forces. Also, individuals often reinforce their own behavior leniently or noncontingently, and some researchers have introduced external reinforcement to encourage strict self-reinforcement. Self-control techniques have been carried out primarily on adult outpatients. However, studies have been conducted with children and adolescents and the procedures have the potential for becoming a major intervention strategy.

## Social Learning Theory

As noted earlier, the conceptual rationale for the social learning model draws heavily on research in behavioral and cognitive psychology. The basis of this theory relates environmental and cognitive events to behavior. The bulk of the theoretical and applied research in this area has been conducted by Bandura (1969, 1977), who has developed a comprehensive theory that, although derived from behavioral principles, considers cognitive variables. Bandura's research focuses on the role of cognitive processes in observational (vicarious) learning. According to Bandura, an individual can learn to respond correctly by watching another person perform the task; thus, he has given considerable attention to the importance of imitation in learning. The instructional strategy of imitation has been widely applied to handicapped individuals in the classrooms.

The social learning theorists have a pragmatic, functional view of social development. They define a socially well-adjusted child or adult as one who interacts with the environment in a way that produces satisfying and

rewarding consequences and minimizes the occurrence of aversive or punishing events. The optimal balance between the negative and positive interactions will vary according to the characteristics of a given person and the characteristics and limitations of a given environment. Therefore, the "optimal" behavior of different people will vary, both within and across settings.

Social learning theorists believe that people's experiences in interacting with their environment affect their behavior. They reject the conceptual framework of "stages" described by developmental psychologists which focuses on hierarchical development of behavior. In the social learning paradigm, the appropriateness of behavior is evaluated through either the person's self-evaluation of a given behavior or a value judgment of other persons in the position of power; the emphasis of intervention is to change behavior so it will be more adaptive and so that others in the environment will reinforce it. Thus, social interactions are directed more positively and the natural opportunities for reinforcement are increased.

Wood, Spence, and Rutherford (1982) have provided seven principles from social learning theory which can be used to guide the implementation of educational programs for the emotionally disturbed. The authors summarized the following principles from a comprehensive review of social learning theory:

1. Behavior occurs in a continuously interactive system;
2. Cognitive and affective factors are hypothesized to play an important role in human behavior, but observable actions remain our primary data;
3. For purposes of analysis and planning, it is useful to speak of fundamental "behavior contingency units";
4. Much social behavior is learned by observing the behavior of real or symbolic models;
5. A key instructional tool for social learning interventions is the restructuring of the special program environment to elicit and reinforce the social behavior the teacher wishes the student to learn and use;
6. The goal of social learning interventions is to have students learn, produce and practice approved behavior at all times;
7. Generalization of approved behavior is planned (pp. 240-243).

Both social learning theory and cognitive behavior modification are important extensions of applied behavioral analysis and represent promising new interventions for emotionally disturbed children.

## Conclusions

An historical review shows tremendous changes and variation in educational strategies and programs for the emotionally disturbed. Educational services in the public and private educational establishments have become more effective and more comprehensive. As a service discipline, special education has assumed the major responsibility for educating the emotionally disturbed and an increasing number of these children and youth are receiving appropriate educational services.

Educators have become a great deal more objective and knowledgeable about the causes of behavior disorders. In particular, behavioral technology has significantly advanced our effectiveness in behavioral intervention. Using applied behavior analysis procedures, we can pinpoint the specific event associated with the adaptive or maladaptive behavior, and we can plan powerful and appropriate intervention strategies. Behavior analysis has focused intervention on present events that have been shown to be directly related to behavior; it has resulted in abandonment of the traditional focus on intrapsychic causes or the etiology of behavior disorders. Applying behavioral strategies has increased our skills in establishing systematic procedures such as record keeping and performance data collection and analysis. Most recently, data analysis procedures have enabled us to make more effective decisions on interventions.

An improved technology for program evaluation coupled with increased skills in applying these techniques and the emergence of behavioral change as the major criterion of program effectiveness enable us to determine more effective models and programs. It is hoped that we will soon be able to improve treatment by matching intervention strategies and models to specified conditions and types of disorders. Also, our increased precision in describing intervention procedures will enable us to replicate various treatment models.

Special educators are now among the most skillful applicators of behavioral research results in natural settings. We have made significant progress as we have shifted the basis of our educational programming from "intra-psychic disease" conceptualizations to basic research in learning theory.

While our greatest gains have been made through the systematic application of behavioral principles and procedures in school settings, many educators now are beginning to doubt that a strict behavioral approach is sufficient in designing academic and social interventions. We are seeing evidence that developments in cognitive behavior modification offer a more comprehensive approach to behavior management. Such an approach is consistent with the great amount of evidence that children's behavior is affected by their observation of the behavior of others.

Within this same framework, social learning theory has emerged as a cluster of conceptualizations that are attractive to educators because social interactions are a major source of both reinforcement and punishment for children. Educators see a theoretical model that can presumably account for social influence as extremely useful as they work with children in social situations. Despite interruptions from nonscientific fads and fancies, the overall progress of education during the past 50 years, and especially since 1960, has been tremendous.

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# Cooperative Full Service Delivery to Emotionally Disturbed Students

Frank H. Wood

*Considerations for Planning Classes for the Emotionally Handicapped* is the title of a small booklet authored by Hollister and Goldston, which the Council for Exceptional Children published in 1962. The authors' purpose, as stated in their preface, focused on the need "to identify the essential psychoeducational processes" (p. i) operating in classes for this group of special needs students "to promote better communication between programs and more rigorous efforts at program description" (p. i). In the booklet, they outlined desirable features of 68 programs they studied. Their recommendations may be taken as an indication of what was considered desirable practice almost 20 years ago, at a time when public school programming for emotionally disturbed students had been stimulated by mandatory legislation passed in several states.

It is instructive to look at some of the desirable program characteristics Hollister and Goldston (1962) list in the sections entitled, "The Clinician-Educator Liaison Process" and "School-Home Liaison Process." Mentioned among desirable characteristics of clinician-educator relationships are: "consultations between educators and clinicians on specific problems, teacher observation reports to clinicians, periodic review of case dynamics by clinicians with teachers, use of mental health and educational consultants in work with teachers, and use of therapeutic supports for teachers" (p. 23). Among desirable characteristics of the school-home liaison process are: "periodic interviews and interpretations of the pupil's progress, parent training and education, parent counseling, and casework approach to home" (p. 24).

All of these would be considered desirable characteristics of a comprehensive service delivery system today. How much progress has been made over the years in implementing these ideas?

Undoubtedly, some school programs for emotionally disturbed students are linked to well-developed supportive service systems. A national survey published in 1977 (Challenges for Children's Mental Health Services) showed that areas remain where present accomplishments fall well below what experts consider desirable. The 10 services most often mentioned as needing to be improved, developed, or implemented were to:

1. Train and counsel parents to foster healthy mental development in children.
2. Provide early detection and referral for appropriate intervention.
3. Educate all children in life management skills.
4. Base training of educators on developmental and humanistic approaches.
5. Strengthen and support families.
6. Provide comprehensive health care.
7. Improve service coordination and accessibility.
8. Provide community-based outpatient treatment.
9. Train teachers about the needs of handicapped children.
10. Provide community-based residential treatment in non-hospital settings. (pp. xii-xiii)

All of those listed are related to the provision of educational as well as mental health services to emotionally disturbed children and youth who do not need residential treatment, or to the prevention of serious emotional disturbance in this group. The importance of interagency coordination is mentioned frequently in the elaborations of these basic needs statements.

The concerns listed in the 1977 survey are very similar to those in the 1962 booklet. Cooperation among professionals and agencies, then and now, is seen as highly desirable but difficult to realize, much talked about but seldom observed. While the 1977 statements are not well developed as a model, they can be used to structure our intentions for the development of service delivery systems.

## Some Assumptions

The procedure followed by many special educators in planning and providing instruction to special needs students is accurately described in terms of a disease or disability model, the conceptualization of educational service delivery based by simplified analogy on allopathic medical

practice. This disability model rests on the assumption that the problem to be treated is lodged in the student, a result of a physiological or characterological defect or weakness, or of faulty past learning. Special educators guided by this model make use of standardized assessment procedures, and once the problem has been identified and labeled, they implement intervention procedures prescribed for such a problem. In fact, many of the treatments for disturbed or disturbing behavior typically characterized by this model are administered by physicians or mental health specialists who treat the special student through medication or psychotherapy in isolation from the classroom. Teachers are only peripherally involved in the treatment process. Indeed, educators are frequently viewed as naive about the causes and appropriate treatment of emotional disturbance in children, and therefore, as prone to adopt superficial treatment methodologies that may obscure the true nature of the child's problem and interfere with more appropriate treatment. "Schools have been quick to accept the ahistorical, easily administered, symptom- eliminating techniques that promise to help control behaviorally difficult students," Silverman (1979, p. 63) wrote recently in criticizing educational practice viewed from this perspective.

The approach to developing a service delivery system based on interprofessional and interagency collaboration proposed in this paper is based on the assumption that the disease or disability model of problem behavior and its treatment is too narrow. Certainly, some disturbed behavior does seem to be focused in characteristics of the individual student and may be most efficiently treated by noneducational interventions. But, the great majority of school behavior problems are better conceptualized as the result of interactions between the personal characteristics of the individual and the characteristics of his or her environment, as both are influenced by the ongoing behavior of that individual and others, a concept that has been expressed by Bandura (1977) as a three-way interaction.

Furthermore, it is assumed here that the kind of interventions Silverman (1979) characterizes as "ahistorical, easily administered, symptom-eliminating techniques" have as important a place in the overall plan of intervention for some students as medication or psychotherapeutic counseling have for others. The goal of the service delivery system proposed is to coordinate the therapeutic efforts of groups of people without rejecting their potential contributions to behavior change based on their preferred intervention procedures.

The model that best fits the service delivery system described in this paper is one which has been called "ecological." Apter (Note 1) lists the following principles as characteristics of an ecological view of disturbed student behavior:

1. Each child is an inseparable part of a small social system.
2. Disturbance is not viewed as a disease located within the body of the child, but rather as discordance (a lack of balance) in the system . . . .

3. The goal of any intervention is to make the system work; and to make it work ultimately, without the intervention . . . .

4. This broader view of disturbance gives rise to three major areas for intervention: a) changing the child, b) changing the environment, c) changing attitudes and expectations. (p. 5)

Intervention, when thus conceptualized, is indeed a complex, multifaceted process. This complexity, rather than a lack of commitment, is the reason why the desirable events listed by Hollister and Goldston (1962) have not yet been realized in practice. By accepting this complexity as a given, however, we may be able to make more adequate progress in bringing these desired events to realization during the next 20 years.

## Schools and Other Social Systems

Apter (Note 1) refers to the child as part of a "small social system." Johnson (1970) has described schools as social systems in which there is "a recurrent pattern of events, differentiated from but depending on the larger environment" (p. 20). These events "involve the flow of energy from the environment through the system itself and back into the environment. While the energy is within the system it is transformed" by the people and the physical environment of which the system is composed (pp. 20-21). The school as a social system is what Johnson calls a "social organization." Social organizations are differentiated from other kinds of social systems by the following features:

1. The group maintains itself by recruiting and training personnel.

2. The group functions performed by persons filling roles within the organization are well specified.

3. The organization possesses a clearly defined hierarchy of authority.

4. Adaptive structures provide information about the adequacy of organizational functioning and the changing character of the external environment.

5. Common norms and values buttress the authority structure of the organization.

Behaviors that define school roles like "teacher" and "student" are strongly reinforced within the organizational structure of the school. Deviant behaviors, which define "disturbed student," for example, are punished. Furthermore, other role behaviors are equally strongly reinforced or punished within the other social organizations with which we are concerned, such as the family, the juvenile court system, the mental health system, and the welfare system.

Keeping these basic organizational concepts in mind will help as we define the problems that arise when special educators propose a comprehensive, coordinated mental health service delivery system for dealing

with disturbed students. Johnson's listing of characteristics of the organization makes it clear that more is involved than the willingness of individuals to collaborate in service delivery. Their collaboration will be made difficult, if not impossible, if it is not supported by their member organizations. The special or regular class teacher who wishes to consult with a local mental health clinic regarding a student's problem behavior will find it hard to proceed in the face of school policies that forbid the initiation of such referrals by teachers (formal organizational structure interference), or the opposition of a building principal who expresses strong personal opposition to involving "outsiders" in school affairs (informal organizational structure). One parental partner will find it hard to cooperate with the school when the other opposes such cooperation. Sometimes agency personnel are bound by organizational rules denying services to children whose parents will not participate in concurrent group therapy.

Comprehensive service delivery requires intelligent planning for dealing with a complex group of organizations, each with its own rules for its members, its own environmental constraints, and its own rules for the interactions of its members with the larger environment. Our task is beginning to become clear: How do we facilitate role and rule changes within these organizations to make possible the collaboration that a comprehensive service delivery system requires?

## Factors Supporting Service Delivery Change

The major reason for the failure of past efforts to implement service delivery system changes has been an underestimation of the size of the task. Planning has stressed the desirability of change, but implementation has been hopelessly weak in resources. Figure 1 suggests some important resources for producing and maintaining changes in service delivery; these resources are grouped as antecedents or reinforcers of change. Note that most of the antecedents could alternatively be conceptualized as negative reinforcers for change.

Legislation can mandate changes in service. Recent examples of mandating legislation affecting the delivery of services to emotionally disturbed students are Section 504 of the Rehabilitation Act of 1973 (PL 93-156) and the Education for All Handicapped Children Act of 1975 (PL 94-142). Court decisions can also produce changes, but their impact may be weaker because courts do not share the legislative power to authorize supporting resources. Community advocacy groups can be effective antecedents for change, in part because of their recent history of success in obtaining court or legislative support when their initial demands have not been met by service agencies. Administrative proposals ranging from the development of organizational plans to actual skill training are less powerful factors in the change process now than in the past because ad-

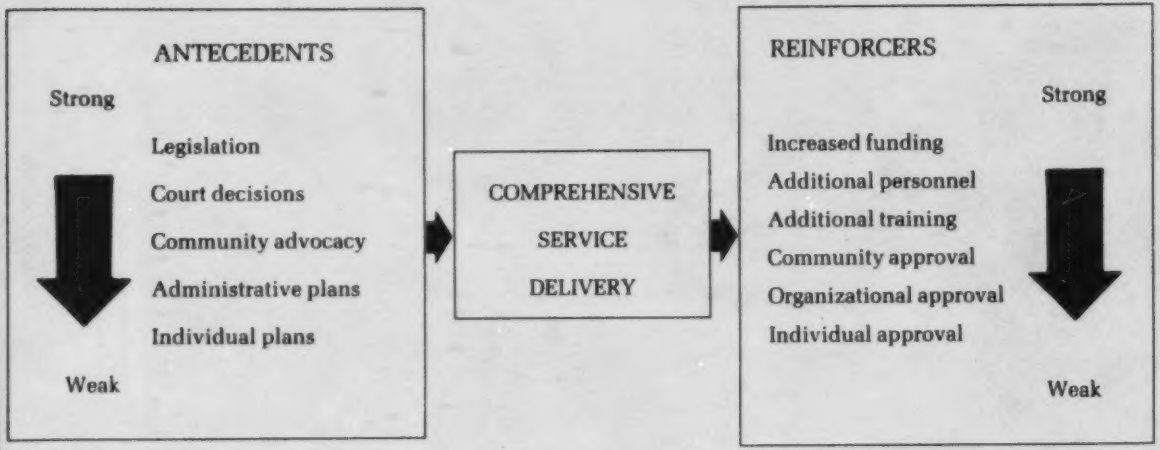


Figure 1: Factors Supporting Comprehensive Service Delivery

ministrative initiative has been weakened by legislation and regulation, and agreements with employee organizations. Proposals made by individual members of organizations are the weakest of all.

Financial support, because it is a common denominator for all resources, is the most powerful reinforcement for changes in service delivery systems. Assignment of personnel to collaborative efforts usually, but not always, requires additional financial support. Community approval can be effective as a reinforcement for change if it carries with it the promise of additional financial support as needed, or if it poses the threat of aggressive advocacy for change. Organizational approval can sustain behavior for a considerable time, even in the absence of stronger reinforcement, but the support of only a few members will prove inadequate to sustain change for more than a short time, except from the few extraordinarily committed individuals.

After considering the contingencies that support or discourage a broad, cooperative response to emotional disturbance in school, the concerned educator, parent, or citizen is ready to tackle the task of increasing cooperation. There are very few situations in which service delivery cannot be improved by the implementation of even modest collaborative programs, so long as they are well designed. We do not have to involve everyone to make a difference. From the perspective of the ecological model, improvement anywhere benefits the whole system.

## Legislation and Court Decisions

Following a series of court decisions that established the right of handicapped children to a free public education, the Education for All Handicapped Children Act of 1975 and the regulations implementing it have prescribed the form an appropriate education for these students should take. This legislation supports comprehensive programming efforts at several levels in states that accept the related funding. Local school districts are required to develop plans for programming for all special students and individualized education programs (IEPs). State education agencies are required to prepare plans for implementing educational services for all students in the state.

There has been considerable discussion about the impact of this legislation on educational programming for emotionally disturbed students. The definition of emotional disturbance in the implementing regulations seems to limit the application of the law to only the most seriously emotionally disturbed, a group from which the "socially maladjusted but not emotionally disturbed" are specifically excluded. Does this mean that no services are mandated for the mildly or moderately emotionally disturbed student? Raiser and Van Nagel (1980) fear that this will be the case, and Kauffman (1980) argues strongly that PL 94-142 will have the effect of punishing schools that provide special services to the mildly and moderately disturbed.

While the full effects of the legislation are not yet clear, partly because the implications of some provisions are still being debated in the courts, a case can be made that the general effects will be positive for moderately as well as seriously emotionally disturbed students. For one thing, it is clear that the public schools have an obligation to provide an educational program for all children, and teachers cannot look to exclusion as a solution to the problems of managing certain students in their classes. This is leading teachers to ask for assistance from administrators, and administrators in turn to seek help from outside the system. In addition, many of the students receiving special education support services on a part-time basis under categorical labels like "learning disabled" have behavior problems as a secondary characteristic. Regular classroom teachers are eager to receive practical help from special educators or mental health specialists.

It is also worthy of note that the Office of Special Education and Rehabilitative Services estimates that large numbers of emotionally disturbed students are currently going unserved and is pushing states to see that these students are located and served (Grosenick & Huntze, 1979). The result may be the writing of more IEPs in which social behavior is the focus of the planned interventions. Regulations require that parents be present at the IEP conference and formally approve the resulting program for their child. Like the federal, state, and local plans, the IEP is an administrative plan or agreement committing several people to collaborative efforts to change the school, and perhaps, other environments to improve adjustment by individual students. Of course, at the present time, too many IEP conferences seem to be perfunctory meetings. Goldstein, Strickland, Turnbull, and Curry (1980) reported that the IEP conferences they observed usually involved teachers explaining an already developed IEP to parents. Thus, although the IEP is sanctioned by the school system, it is typically an agreement of relatively narrow scope agreed to by a small number of people. The IEP's potential for becoming a more comprehensive statement coordinating service delivery is being delayed by the debate over the issue of who is responsible for funding any related physical or mental health services, noneducational in nature, that are mentioned as part of a student's educational program. Some governmental agencies have argued that it is the responsibility of the local school system to pay for these necessary related services. Others point out that the schools lack the financial resources to meet such an obligation. The issue is still being litigated and, in the meantime, school administrators are being very cautious about the content of the IEPs being written. As emotional disturbance is often generalized across several situations, both in and out of the school, an IEP drawing on resources outside of the school would be very desirable. For the present, however, the school remains the only system obligated by law to provide free services to emotionally disturbed children and youth.

Not only do the regulations implementing PL 94-142 fail to make clear guarantees of services to the more moderately disturbed, but the law's influence has been weakened by what local education agencies generally

perceive to be inadequate supporting funding. The funding authorizations were never intended to provide more than partial support for the mandated special services, with the remainder to come from state and local sources. Thus, each additional student served costs local taxpayers an additional amount.

IEPs tend to be weak because they are severely limited in scope. Still, as has been said, these administrative plans provide a model for planning comprehensive service delivery, however limited and flawed its implementation. Those concerned about improving services to the seriously as well as the moderately emotionally disturbed should seek to extend the benefits of this kind of planning to more students through revision of the current eligibility definition and support for judicial and administrative rulings that extend present services.

## Interagency Agreements Outside the Framework of PL 94-142

Most interagency agreements that establish collaborative plans for service delivery to the emotionally disturbed are focused on the needs of seriously emotionally disturbed students. Here again, however, promising models exist that may be extended in the future. Pittenger (1979) has described the agreement that links the services provided to delinquent youth in Pennsylvania by the State Department of Welfare and Education. Implementation of this agreement was supported by the assignment of a staff member of the Department of Education to a liaison role. The plan is described as a major step toward coordinated service delivery.

Kirkbride and Rohleder (1978) describe a joint agreement among 10 school districts establishing a Kentucky Re-Ed program. An agreement was also reached between the Re-Ed program and a regional mental health center to provide a variety of direct and consultative services to the program. In this case, the educational agency was the host for the program and a mental health clinic liaison was assigned to coordinate any needed clinic services. The following quotation gives an idea of the kinds of service that can be provided through this kind of cooperative agreement:

> Consultation was provided in the form of case consultation, referral services, and program consultation. Case consultation was given on a regular basis. Recommendations were often made as it related to children possibly in need of medication evaluations, neurological evaluations, formal psychiatric evaluations of different types of interventions in working with the child and his family. Such specific types of services were made available through specific mental health centers as need dictated. Consultation services also included interpretations of reports sent to Re-Ed from other mental health agencies or agents. Referral services to other care-giving agencies based on the child's needs was another facet of consultation services. At the time of admissions, referral to another service may have been indicated when Re-Ed was not the alternative which would

best meet the needs of the child and family. Program consultation was supplied by a variety of professionals from within the Mental Health Center system. Consultation was given by Medical Records technicians, legal representative, branches of fiscal management and program management and development. Primary in program consultation for River Region (Mental Health Center) was that of interpreter to Re-Ed. River Region aided in the interpretation of the myriad of federal, state and local mental health policies, guidelines, and standards. It also aided in the establishment of internal guidelines and policies.

Direct services have taken a variety of forms such as professionals working with the child, assistance in providing further diagnostics and in working with the family in accepting Re-Ed as an alternative service plan for them and their child. River Region professionals were involved in more traditional types of treatment with parents while a child was at Re-Ed. In this situation the River Region personnel and the Re-Ed personnel worked closely in coordinating efforts for the family. The child, while in residency at Re-Ed, may also have been seen at a River Region Center for individual, family or more traditional group therapy. At the time of termination from the Re-Ed program, referrals were often made to River Region's Children's Programs and/or other children's services in the child's area of residency for continued services. (p. 128-129)

While the focus again is on the students enrolled in a special school, and thus probably considered seriously rather than moderately emotionally disturbed, this Kentucky program gives an encouraging example of what can be done when well-thought-out administrative plans are backed by the commitment of funds and personnel.

"Turf problems" are often mentioned when such interagency cooperation is discussed. Sheare and Larson (1978) have shared their analysis of how friction and misunderstanding were minimized in a joint mental health-public school program for emotionally disturbed students and their families. They advocate facing such issues squarely at the beginning.

Program ownership, if not clearly delineated, invariably leads to power struggles between agencies and results in disjointed staff relationships. Initial planning efforts were aimed at establishing program ownership and control issues, with the realization that the failure to do so would result in hidden agendas and program failure. (p. 543)

The key to successful cooperation, according to Sheare and Larson, is a stress on the idea that agency contributions are distinct, but of equal value. Both agencies provided direct as well as assessment services, rather than one providing assessment services alone, leaving implementation of interventions to the other. In this case, the program actually has coadministrators, one from the mental health agency and one from the school. Sheare and Larson report that this system, while it sounds cumbersome, works well in practice.

Another type of interagency agreement leading to cooperation in addressing the problem of emotional disturbance in schools in a broader context than in the classroom has a more negative tone, but is reported by various administrators to have a beneficial effect. This type of agreement involves school-juvenile court cooperation around issues like truancy, probation,

and child abuse. The first two produce interagency cooperation focused on the student; the third focuses on the parents. Such agreements, whatever their intent, are typically perceived by students and parents as coercive rather than supportive, but their results may be positive if the implicit sanction of incarceration or monetary fine is not imposed and resources supportive to the student, parent, and school can be obtained. The fact that many school administrators turn to such procedures supports the observation that school personnel seeking to develop interagency agreements may feel obliged to turn to unpreferred options because of a lack of resources to support other possibilities. In this case, as with the regulations of PL 94-142, desirable professional practices occur only when they are mandated.

## Coordination of School Services

### Roles

Schools as organizations do not have a history of staff collaboration. Typically, personnel function independently, working in their own assigned spaces and passing students back and forth for instruction or other kinds of intervention. The number of roles in providing direct or indirect service to students with special needs may be extensive. The following list of persons serving on educational plan committees charged with responsibility for determining a child's eligibility for special education placement or services reported by Gilliam (1979, p. 467) is illustrative. They have been listed here in order of actual importance in the meeting as rated by the participants themselves:

1. Special education teacher
2. Special education consultant
3. Psychologist
4. Special education supervisor
5. Special education director
6. Guidance counselor
7. Regular education teacher
8. Others
9. Parent
10. Social worker
11. Other administrators
12. Principal (p. 467)

Gilliam interprets this ranked list as indicating that high ranking may be associated with greater contact with the child and the child's family and

with possession of more data to contribute at the meeting. A major task of the school is to coordinate the activities of personnel filling these roles so that collaboration means more than participation in a joint planning meeting. Fuller participation can be promoted in a variety of ways.

## Building Disciplinary Policies

Building principals can play an important role in initiating joint staff and parent planning, which can lead to the adoption of school-wide disciplinary policies. While such policies may not remove the causes of emotional disturbance in classrooms, they can provide teachers, students, and parents with clear guidelines about how problem behavior will be managed. Lacking such guidelines, many schools reveal haphazard, inefficient, and inconsistent behavior management. The establishment of guidelines should be followed by staff training and parent information meetings as necessary. Of course, the administrator who begins the development of such policies should not expect that a clear consensus will emerge from group discussions. Therefore, he or she should be prepared in advance to assume leadership in establishing the policies that are viewed as sound and appropriate and as having substantial support. Such policies will gradually attract the support of all but a few "die-hards." Libbey (1980) found that a variety of disciplinary styles existed among the teachers she surveyed. She also reported that only those in the group who were in transition, that is to say, seeking a different style of discipline, seemed dissatisfied with their current style. Those who had a firm position, regardless of what it might be, felt comfortable with what they were doing. Informal observation suggested that most students were able to accommodate to the different styles without obvious stress. The fact that teachers do differ in their personal styles for behavior management, despite the existence of a general building policy for discipline, is another factor that the thoughtful administrator will take into consideration when dealing with problems of disturbed student behavior. Students who have difficulty adjusting to certain disciplinary styles may be much more at home with some teachers than others. For such students, the right match with a teacher may be the difference between an achieving role as a well-adjusted student and that of a school troublemaker. Here again, the building administrator can achieve better service delivery by serving in a linking role to coordinate the efforts of the school staff.

## Consulting Resource Teachers

Many schools now have staff persons who are called "resource teachers." Despite the role name, which suggests active support to the regular classroom teacher, most resource teachers seem to function in isolation, seeing small groups or individual students for short periods of time during the school day and communicating with regular class teachers occasionally at conferences or through written messages. Evans (1980) reported that

her sample of resource teachers spent less than 5% of their time in consultation with regular class teachers, although a survey of the resource teachers, regular class teachers, and building principals revealed that the time spent should be at least twice that amount. Others (McKenzie, 1972; Newcomer, 1977) have advocated redefinition of the resource teacher role to emphasize the consultation function. They and others (Haring, 1977) have reported on the usefulness of such *consulting* resource teachers.

The problem preventing the achievement of broader implementation of this idea can be described in terms of the factors shown in Figure 1. The establishment of antecedent conditions in the form of administrative plans for consultation by resource teachers, with accompanying exhortations to practitioners, but without adequate training or redefinition of responsibilities to enable resource teachers to fill this linking function provide no lasting changes. As Little (1978) has said,

> Effective communication with regular classroom teachers requires that resource teachers be experts in their own area and also possess change agent's skills. Trainees need to enhance their skills in such traditionally neglected areas as interpersonal relations, principals, communication techniques, group process, systematic problem solving, and in- service delivery. Without strong competencies in the change-agent areas, technical diagnostic and remediation expertise within the consultation process becomes useless and the entire process ineffective. (p. 355)

Well-trained consulting resource teachers and administrators plan for school-wide responses to emotionally disturbed behavior in ways that facilitate positive student and staff growth.

## Aides and Volunteers

Some schools have increased their capacity for responding constructively to disturbed or disturbing behavior through the use of volunteers or specially trained paraprofessionals. Platt and Platt (1980) have described how one school system obtained strong support from community volunteers. A teacher-parent committee was set up to plan the program. They chose a parent to serve as an unpaid volunteer coordinator. Volunteers were recruited by letters and telephone calls. The coordinator planned schedules, assignments, and orientation sessions, and coordinated a babysitting service as needed. Teachers prepared packets to guide tutors. The volunteers assisted teachers in the regular classroom. Such assistance made teacher time available for working on social development or behavior change programs. The author knows of another instance in which a capable volunteer was recruited to work on a weekly basis with a group of students whose restlessness and distractibility made it difficult for them to be accommodated on excursions with the rest of the class. The volunteer planned small group experiences that provided practice in approved behavior outside the school and accompanied them when they went on trips with the larger group.

A major weakness of the use of volunteers as part of a comprehensive service delivery program is the lack of sustaining reinforcement. It is not clear how long the program reported by Platt and Platt lasted. In the second example, the volunteer was unable to continue during a second year despite the enthusiastic gratitude of the school staff. Some schools have established longer lasting programs based on the use of paraprofessionals who are paid, but at a lower salary than teachers.

Boomer (1980a, 1980b) has discussed the importance of proceeding carefully when employing and using classroom aides. He maintained that it is incorrect to think of paraprofessionals as unskilled. Many possess highly developed skills, but because their experiences vary greatly, their skills need to be evaluated in the context of the position to be filled. As classroom aides, they can be important assets for the classroom teacher in helping to manage the environment and to stabilize the behavior of students whose low tolerance for frustration or high physical energy levels makes them prone to disruptive behavior. Boomer's suggestions for structuring communication with classroom aides are sound, and indeed, apply to communication among all members of a team working to reduce disturbing behavior. He suggested involving aides in preacademic year planning and regularly scheduled meetings, while following up with written communications about important matters, and on-the-spot communication as necessary.

Rardin (1978) has described a program in which aides are given special training as consultants with teachers about classroom behavior problems. The "management assistants," as they are called, accept referrals from teachers, observe behavior in the classroom, discuss possible changes in the classroom and ways to build environments that support approved behavior, provide a linkage with other staff, including special education personnel if needed, and monitor changes in behavior. Beginning in one school, this program has now been replicated in all buildings of the Roseville (MN) Public Schools. It should be noted that Rardin selects persons who have good understanding of the dynamics of interpersonal behavior and who can communicate effectively with others. She then trains them for the special tasks of the management assistant. The fact that the assistants are not teachers, and are, in a sense, of lower status than teachers in the formal hierarchy of the school, serves to minimize friction with classroom teachers. They *assist* the teacher in problem solving rather than coming into the room as experts to impose their ideas. The management assistant program represents an interesting use of personnel with low formal status to promote interdisciplinary collaboration in managing problem behavior. The program has succeeded, and the aides have achieved status through demonstrating their usefulness to teachers.

## Specialists

Other programs have made use of teachers, psychologists, social workers, and psychiatrists to provide support to regular classroom teachers work-

ing with the moderately emotionally disturbed and to activate broader support systems. For example, the Department of Child and Adolescent Psychiatry at the University of Minnesota Hospitals and the Minneapolis Public Schools, the school districts in which the hospitals are located, jointly employ two school liaisons (Gedo, 1978). Yearly the Department offers both inpatient and outpatient service to more than 100 school children from a wide geographical region. School personnel are invited to admission and exit conferences if they are able to attend. The school liaisons provide an outreach from the hospital-based program to the home schools. Meeting with local school personnel, the liaisons interpret the hospital's reports and recommendations in the context of what the schools have to offer. Sometimes they act as advocates for children the hospital staff believes can be maintained in a home-school situation, but whom the schools wish to exclude by sending them to a residential facility. The liaison program provides consultation from experienced educators who can offer many practical suggestions to local school personnel. The liaisons' work is made more difficult by the fact that they are trying to "sell" a plan for action without being able to commit resources to support program implementation. At times, of course, they can help the schools to obtain support from other agencies.

Local school districts have also provided specialized supporting services to teachers by placing professionals usually available only for limited consultation in roles where they can provide direct service, support, and training. In Montgomery County (PA) Intermediate School District, a program (Anderson & Marrone, 1977) has trained classroom teachers to work with small student groups as a means of resolving school conflicts and fostering healthy personal development. Training and support is provided by a social worker/psychiatrist team that works directly in the schools. Counseling and training is also extended to parents. In the Hopkins (MN) Public Schools, the SAIL program (Student Advocates Inspire Learning) (Balfour & Harris, 1979) involves adolescent students with high rates of absenteeism whose in-school behavior has been characterized by conflicts with teachers, failure in academic coursework, and drug use. A social worker/counselor team has trained teachers on special assignment to act as small-group leaders. The groups focus on setting expectations for student performance using a Goal Attainment Scaling format and following up with discussion of how goals can be attained, as well as whether past goals were reached. Group sessions are supplemented by individual conferences. The SAIL staff also allot time for face-to-face contact with regular classroom teachers and telephone contact with parents. Students are helped to work through problems with teachers and to find help from other agencies if needed. While the latter two programs are, in many senses, models, both had outside grants to support their initiation. As budget constraints begin to cause program cutbacks, it is hoped that they can be maintained.

## Schools and Parents

Parents of the emotionally disturbed have not seemed to find participation in advocacy groups as rewarding as have parents of other groups of handicapped children. For example, no organizations exist which are similar to the National Association for Retarded Citizens or the Association for Children with Learning Disabilities. The aversive quality of the label "emotionally disturbed" may inhibit the parents from organizing around it. It is worthy of note that the National Society for Autistic Adults and Children has adopted statements criticizing the historical classification of autism as "serious emotional disturbance." The distinction of being emotionally disturbed is not only to be avoided, but is to be repudiated! A few local and state parent organizations exist, but they lack the strength of other parent organizations for the handicapped. This does not mean that parents of the emotionally disturbed lack concern for their children. It does indicate that they tend to seek solutions to their problems as individual families rather than as members of groups. Yet, because of the weakness of the formal mechanisms for interdisciplinary and interagency cooperation, parent advocacy on behalf of moderately emotionally disturbed students is badly needed.

The history of the relationships between schools and the parents of moderately disturbed students is full of mutual recrimination and misunderstanding; but there are also many examples of effective cooperation. The first step to building cooperation seems to be the willingness to accept joint ownership of the problem. Rather than demanding assistance from parents in changing students' in-school behavior when their understanding and skills in managing their children is expected to be less than those of trained professionals, school personnel should approach parents assuming that they are ready to help if able and if supported.

Stein shared a sensitive story of work with parents in an article in *Young Children* in 1967. She and her staff of welfare workers sought to implement a plan to teach low-income mothers sound principles of child rearing. Fortunately, because of her sensitivity to interpersonal relations, they began by asking the mothers to talk about their own experiences as children and as parents. As the mothers shared the story of their problems and their ingenious ways of coping with them, the professionals' respect for these women's knowledge of child rearing grew. Soon, they realized that they no longer had ideas about child rearing to "lay on" these mothers. The training program that developed was based on mutual sharing and co-counseling of both parents and professionals.

This sensitive approach characterizes programs like those described by Bricker and Caruso (1979) and Warfield (1975). In these programs, school personnel began with a commitment to involving parents and then found ways to do it. Bricker and Caruso "found it essential to provide parents with social service assistance and counseling as well as educational in-

formation and skill training" (p. 109). In a sense, parents, as well as their children, were clients, until the parents were prepared to provide the supportive services desired by the school. Their program employed a parent-resource liaison for whatever assistance needed to enable them to become effective coworkers with the school.

There are many pitfalls in building joint support systems with parents of emotionally disturbed students. Marion (1980) has written perceptively about the special problems of communicating with the parents of culturally different children. Because such students are too frequently at the center of emotional disturbance in the schools they attend, and because the problems he describes are typical of many other parents of students considered to be school problems, his comments are especially relevant. He notes that many parents may feel that their children, rather than being accurately described as "behavior problems," are actually gifted, creative, and popular, but "on the outs" with school personnel. His descriptions of these parents as out-of-touch with advocacy organizations and "social cliques that obtain and exchange information on an impromptu basis" (p. 619) fit many parents of the emotionally disturbed. Approached by the school with a message of blame, they become angry and defensive, but approached with sensitivity and concern, they are eager for information.

Marion suggests that these parents need advocates rather than critics. Demands made on them should be appropriate. Educators should expect, accept, and work through parent anger if it appears. Parents should be assisted in learning their rights and responsibilites under laws and regulations; they should be supported in learning to work with professionals. They should be helped to take an active part in planning conferences and guided to outside support and advocacy groups if they show an interest in them. As Marion says, rather than being scapegoats for the problems their children may be having in school, parents should be helped to "find satisfaction in learning what can be done for their child and working actively for the child's maximum potential development" (p. 621). If the schools do not involve parents in such constructive ways, they may eventually find their way to outside advocacy groups who will support their case against the school using adversary methods.

The family and the school are two agencies that cannot refuse to accept responsibility for students assigned to them for care. Parents and teachers are involved in a joint service delivery system whether they like it or not, so it is in the best interest of all concerned that this relationship be cooperative and supportive rather than antagonistic.

## Conclusion

Full service delivery systems for the support of the education of students with special needs, including the emotionally disturbed, have long been

a goal of parents and educators. Despite the sound reasons for dealing with disturbance in schools from a system- rather than a child-centered perspective, however, we have made little progress in the past 20 years toward establishing interprofessional and interagency collaboration as a norm. A viewpoint expressed in this chapter is that this lack of progress is the result of the complexity of the task and the lack of adequate support for such services rather than a lack of sincere commitment. Therefore, rather than discussing in detail what should be or might be, examples of what "can be" have been presented.

Contemplated in the abstract, a full service delivery system for emotionally disturbed students can be analyzed into lists of roles and functions bound together with orderly flows of energy. Perceived from the field, such service delivery systems appear to be disordered, disjointed, and of unmanageable complexity, fragments rather than a whole, and with no sign of a central nervous system. Rather than being overawed by what actually exists, practitioners should approach such systems with the intention of working on whatever part of it can be improved through the application of the resources and skills at their disposal, confident that if the functioning of a part is improved, the total system will benefit.

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# Administrative Issues in Educating Emotionally Disturbed Students in the Public Schools

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For those in charge of special education programs in local school districts, the handicapping condition of emotional disturbance presents special problems. While federal laws are being interpreted by lawyers, civil rights groups, and the courts, special education administrators must daily decide what is best for the children they serve and must carry out those decisions with their best professional judgment. The administrator plays the role of planner, policy maker and interpreter, mediator, negotiator, advocate, and, too often, scapegoat, when things do not go well. The administrator must juggle budget, policy, and contradictory philosophies and attitudes in an attempt to provide a comprehensive service system.

This chapter is devoted to administrative perspectives on educating the emotionally disturbed student. In many ways, the processes the administrator uses to develop programs for this group of students are not significantly different from the processes that are used for developing programs for students with other handicapping conditions. The administrators must make decisions based upon teaching and administrative experience, data, and current knowledge from the literature about best practices in the field.

Although the average administrator tends to be reactive, an active leadership role is essential for the development of good programs. This chapter will focus on the major issues in educational service delivery to emotionally disturbed students and the elements of an active leadership role associated with providing these services.

There are four major issues that emerge from the numerous concerns of administrators in providing services to the emotionally disturbed. These issues have surfaced because the legislation (PL 94-142 and Section 504) has failed to answer many questions, and controversy and litigation have followed. The four issues are: eligibility; placement; discipline, including suspension and expulsion; and provision of related services, including psychological counseling. Administrators must attend to these issues in order to establish the minimum requirements of a legal program; in this sense, then, they are reactive.

Other concerns facing a special education administrator include the nature of the instructional program, costs, evaluation of programs and services, and maintaining relationships with teachers' unions. These, issues too, are complex and interrelate with the unique difficulty presented by emotionally disturbed students.

Due to the role of public laws and court decisions in the development of administrative policies and procedures for the emotionally disturbed, administrators must pay close attention to the rules and regulations associated with PL 94-142 and Section 504, and to the interpretations of these laws from the Office for Civil Rights (OCR), Special Education Programs (SEP) (formerly Office of Special Education), their state education agencies (SEAs), and judicial decisions. Yet neither PL 94-142 nor Section 504 specifically delineates services for any specific category of handicap. This becomes the administrator's domain. The requirements for service are stated generically and apply to all handicapping conditions. The rules and regulations for each law provide some guidance in the areas of definition, placement, and related services. Each of these laws is monitored at the federal level, Section 504 by OCR and PL 94-142 by SEP within the Education Department (ED), to ensure that agencies receiving federal financial assistance are employing practices, procedures, and policies consistent with the requirements of the law.

Thus, while the general direction of programs was legislated (zero reject, nondiscriminatory evaluation, appropriate education, least restrictive placement, procedural due process, and staff and parent participation), the specifics of implementation were not given. Where the intent was not clear, hearings, judicial decisions, and policy interpretations by regulatory agencies have provided some direction. The administrator must use caution, however, in generalizing from specific court cases to conditions in his or her local district. While earlier cases were class action suits and thus had far-reaching implications, decisions of the last few years have been based upon the facts unique to each specific case and cannot be so easily generalized. However, trends appear in these cases which can help the administrator in developing a district policy that is consistent with legal requirements and that constitutes quality education.

# The Issues Facing Administrators

## Eligibility

Services are provided only after the student has been identified as handicapped, assessed, and found eligible; therefore, the first concern is identification. This is not an easy task with respect to the emotionally disturbed. Who is an emotionally disturbed child? Federal definition for serious emotional disturbance specifies several characteristics:

> (i) The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree *which adversely affects educational performance*:
>
> (A) An inability to learn which cannot be explained by intellectual, sensory, or health factors;
>
> (B) An inability to build or maintain satisfactory relationships with peers and teachers;
>
> (C) Inappropriate types of behavior or feelings under normal circumstances;
>
> (D) A general pervasive mood of unhappiness or depression; or
>
> (E) A tendency to develop physical symptoms or fears associated with personal or school problems.
>
> (ii) *The term includes children who are schizophrenic or autistic. The term does not include children who are socially maladjusted, unless it is determined that they are seriously emotionally disturbed.* (*Federal Register*, 1977, p. 42,478)

The definition includes children who are schizophrenic, but the definition *excludes* children who are socially maladjusted unless they are also seriously emotionally disturbed.

One major problem for individuals at the service delivery level is how to distinguish between the behaviors labeled social maladjustment and those considered indicative of emotional disturbance. Many agencies and professionals, when asked to diagnose a child, often arrive at different conclusions. There are neither data nor consensus among professionals with respect to differentiating between these labels. A contributing factor to this lack of consensus is that professionals, in most cases, reflect the viewpoint and philosophy of their training institution. The staff in large, urban districts can therefore represent many colleges and universities, all with different philosophies and approaches to labeling these behaviors. This can result in a staff with almost as many different criteria for social maladjustment and emotional disturbance as there are staff members. Confounding the confusion over definitional criteria is the relentless pressure by teachers and principals to quit the professional quibbling and get some help for the student.

This identification problem damages the credibility of the special educa-

tion profession with its colleagues in regular education. Regular educators accuse the special educators of playing semantic games as a means of avoiding surly, antisocial, aggressive students who either need help or punishment or institutionalization—or, more importantly in their eyes, need to be gone.

A second facet of the identification problem, even if one excludes social maladjustment from emotional disturbance, has to do with the variance within the category of emotional disturbance. The federal law and regulations, which most states have adopted to guide their own practices, require that the child be *seriously* emotionally disturbed before being eligible for special education services. Guided by federal law and interpretations, states have established their own parameters for identification. The ultimate responsibility for identification, however, falls at the district level, and identification and assessment of emotionally disturbed students are generally based on a diverse set of data generated and compiled by a multidisciplinary team. The major overriding concern to administrators is the cost, in terms of time and dollars, which results from this process.

The value of a comprehensive multidisciplinary team assessment process can be seriously questioned, in light of at least one example.[1] During the 1979-80 school year in the New York City School District, over 40,000 students were referred for the special education identification process, including those who were potentially emotionally disturbed. Individual multidisciplinary evaluations were conducted on these students to determine whether they were in need of special education services. Approximately 38,000 students were subsequently determined to be eligible. One wonders, if teachers are actually identifying students in need of special education services with 95% accuracy and assessments are only legitimizing teacher referral, what is the purpose of the costly assessment process? One purpose of these multidisciplinary team evaluations is to meet the legal state and federal requirements. In this, the local administrator has little flexibility, regardless of the real value of the process.

Given that multidisciplinary team assessment is mandated, the questions of what and how to assess become issues. The process employed by many school districts for identifying students with behavioral problems is heavily influenced by psychodynamic theory and employs projective tests and similar clinical measures. This approach is focused on determining the "real" cause of student's maladaptive behavioral symptoms. Such assessment is not only costly, but its value in instructional planning is minimal. Also, in light of the previous example, one wonders if these assessments can discriminate emotionally disturbed from nonemotionally disturbed students. As an alternative to this assessment, there is a move among some districts toward use of a discrepant model for identifi-

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[1] Personal experience of Jerry Gross as director of Special Education, New York City Public Schools, 1979-1981.

cation which relies on measurement of the degree to which a child's behavior is discrepant from the standards set for the individual child's classroom and, in addition, provides specific information for instructional programming. This latter type of identification process can be much less costly and can encourage the staff to deal individually and directly with the disruptive behavior.

A complicating factor in the identification and service delivery process is the priorities for service as defined in the law. First priority for services are those handicapped children who are not currently receiving an education; the second priority are those children with the most severe handicaps within each disability category who are receiving an inadequate education (PL 94-142, Section 3).

Many emotionally disturbed students have dropped out of school or have been expelled and are not receiving educational services. They qualify under the first priority, but because they are not as visible as many of the severely and profoundly handicapped, they are difficult to locate. There are only vague estimates of their numbers. Clearly, these students need services and are a concern to school administrators, but it will take the cooperative efforts of several agencies, such as the courts, to locate and re-enroll them in the school system.

A final problem related to the issue of identification is the consequence of labeling a child "emotionally disturbed." Because of the social repercussions of the label, administrators many times are hesitant to label a student for fear that they may have to defend this label in court if the student experiences difficulties in adulthood, such as getting a job. The social and possible legal implications of the label make evaluation teams and administrators cautious of misidentification and may, consequently, cause them to deny services.

In summary, each local district, within the parameters of federal and state law, sets its own policies on identification and assessment with regard to emotionally disturbed students. Yet, forced to make meaningful policy, district administrators may utilize criteria for definition and assessment procedures which may not always correspond precisely to the federal definition or intent. The greatest need for those responsible for direct implementation of special education programs is clarification of definition and development of policy for determining eligibility. The profession must more precisely delineate the criteria for determining serious emotional disturbance, including what level of "disturbance" should be excluded, as well as the differentiation between socially maladjusted and emotionally disturbed. They must subsequently develop an identification process that is directly related to programming. Until there is uniformity in the identification process, local special education administrators will continue to be thwarted in their efforts to provide services to this population, regardless of demand.

## Placement

The next major issue facing administrators is determining student placement. There is much pressure from regular educators to remove these children from their classrooms and, if possible, to create special classes that separate them from the regular campus. Building principals do not want to cope with students who exhibit socially unacceptable and aggressive behavior. In general, principals desire to maintain a stable and calm environment in their buildings, both to foster educational growth and to avoid professional embarrassment. Still, the law is clear that, to the maximum extent appropriate, handicapped students are to be educated with nonhandicapped children. For students who exhibit mild emotional disabilities, a strong argument could be made in favor of the regular class placement with appropriate support services. Therefore, special education administrators frequently must, through inservice or staff training, inform, cajole, and convince principals to keep emotionally disturbed students in their home school.

A section of PL 94-142 rules and regulations which is devoted to "comments" specifically discusses some of the issues related to placement. It is very clear, from these comments, that placement decisions must be made on an individual basis and that the school district must have various alternative placements available in order to ensure that the handicapped child receives an education that is appropriate to his or her needs (PL 94-142 Rules and Regulations, 121a.552, 20 USC 1412(5) (B)). Placements can range from services in regular classrooms to resource rooms, self-contained classes, home instruction, hospital instruction, and residential treatment. Other types of placements can also be made. If alternate placements are considered, then the law requires that the child be placed as close to home as possible and, to the extent that it is appropriate, with other nonhandicapped students. Complicating the placement of emotionally disturbed students within the mainstream are the rights of nonhandicapped students, which are addressed in the comment section of PL 94-142. Specifically, this section states:

> it should be stressed that, where a handicapped child is so disruptive in a regular classroom that the education of other students is significantly impaired, the needs of the handicapped child cannot be met in that environment. Therefore regular placement would not be appropriate for his or her needs. (PL 94-142) 20 USC 1412 (5) (B)1)

Again, there are no specific guidelines or criteria to determine how much and what type of disruption is intolerable in a regular classroom, and who is to determine what is intolerable—a multidisciplinary team or a regular classroom teacher. Under these constraints, placement decisions for any handicapped student are rarely easy to make and are often challenged by parents. With respect to the emotionally disturbed, the administrator is faced with pressure from building principals and regular teachers to remove children from the mainstream regardless of the educational implications, while parents may pressure for private facilities.

The option for residential placement can be one of the most difficult administrative decisions. The responsibility for determining need, as well as costs for providing residential placement, have been interpreted through a number of court cases and state rulings to reside with the local school district. Such placement is an option even when the primary needs of the child are not educational. An OCR ruling, "Education for the Handicapped Law Report" (EHLR 257:55), indicated that educational needs are not defined in purely academic or special education terms and that the school district had to pay for residential placement costs related to the child's emotional needs. These decisions, however, are often in conflict (EHLR 501:302; EHLR 501:315) and again require that an administrator carefully scrutinize decisions as well as each individual placement decision.

Another placement issue is expulsion. Expulsion is considered to be a change in placement and thus requires a reevaluation and a revision of the IEP. Building principals have a great deal of discretion and authority to expel students, but with respect to emotional disturbance and other handicaps, they should be required to seek approval from or at least consult with the department of special education. Because this form of disciplinary action is frequently used, it constitutes a major placement issue with building principals. Expulsion as a disciplinary tool will be discussed later in this chapter.

An issue related to placement concerns the instructional options and settings available in a district. Current instructional arrangements for educating students with emotional disturbance or behavior disorders reveal wide diversity from school district to school district as well as within district programs. Some districts offer only self-contained classes for all emotionally disturbed students regardless of severity, while others provide a full continuum of services, beginning with consultation to the regular class teacher in the student's home school, through resource room service, to self-contained classes. Adding to this diversity is the current trend in the organization and administration of special education programs which recognizes the commonality of instructional needs among certain special education categories, especially for children with mild handicapping conditions. In these programs, students are grouped in resource and self-contained classes according to their functional learning needs, even if these students do not have a common label. Recent literature (Hallahan & Kauffman, 1978; Kauffman, 1976; Neisworth & Greer, 1975) has supported this trend. This concept of non-categorical placement makes it much easier to provide special education in less restrictive settings, because one special education teacher can serve a larger number of students who have similar instructional needs. There is a need for comprehensive evaluation of such programs in order to assure that maximum learning is occurring and that, in fact, the functionally grouped classroom is the appropriate setting for the emotionally disturbed child. Informal data gathered from functionally grouped classrooms supports this concept, but systematic, controlled studies are needed for actual veri-

fication, particularly because there is so much resistance and controversy about this instructional concept.

## Discipline: Suspension, Expulsion, Corporal Punishment

With the increasing conservative movement in education and in the country as a whole, tolerance for any type of behavior disorder is waning. Education systems are moving toward an increased emphasis on academics or the "basics" of education. Community groups or committees are being formed to lobby for a return to academic excellence as the major goal of education. Programs of counseling, remediation, and psychological and social work services are at risk in the face of this new movement. Even vocational and career education programs, so important in our recent past, are beginning to be deemphasized. More and more states are legislating successful completion of competency tests before granting a diploma to a student. Although there are positive aspects to this pursuit of academic excellence, there also are risks that only the academically elite and the conforming personality may survive. In the large cities, the dropout rates for adolescents are staggering. Expulsion and suspension figures are large and growing. Discipline problems continue as the major concern of the American public in regard to the educational system.

In the face of all this, emotionally disturbed students who are seen as troublemakers, or are aggressive and act out, may be in for great turmoil. Where previously there was support and a spirit of rehabilitation, there is now a renewed emphasis on conformity and discipline. Without the protection of law and without the advocacy of the special education department of local school systems, there may be successful attempts simply to get rid of these students through a number of means, ranging from expelling students to intimidating students and parents to leave school of their own volition.

With respect to misconduct and discipline, building level administrators must determine whether the misconduct is related to the student's handicap. If a student's inappropriate behavior is *not* related to the handicap, then the disciplinary procedures approved for nonhandicapped students can be used. If, however, the inappropriate behavior *is* related to the handicap, then appropriate instructional interventions and positive disciplinary techniques are required. An emotionally disturbed student's primary defining handicap is inappropriate behavior; therefore, he or she cannot be punished for displaying that handicap. Consequently, such techniques must be listed as options on the IEP for all emotionally disturbed students. In most cases, suspension and/or expulsion are not considered appropriate disciplinary techniques for emotionally disturbed students, and if used, are considered changes in placement (EHLR 551:211).

The controversy regarding the use of suspension and expulsion with handicapped students is evidenced by a growing number of OCR cases

against school districts (EHLR 257:29, EHLR 257:09, and EHLR 257:71). Among the decisions rendered in these cases is a required reevaluation *before* expulsion (EHLR 257:132), a limit on the number of days a student may be expelled during one school year (EHLR 551:164), and limits on when a student may be subject to emergency removal from school (EHLR 551:109).

It is apparent from even a cursory review of these specific cases that procedural safeguards and Section 504 requirements must be closely followed. Appropriateness of the original placement is questioned in many suspension/expulsion cases, and to determine such appropriateness, reevaluation or reassessment must be done. Also, the inappropriate behavior must be evaluated in terms of the handicap before actions can be taken. After all of these procedures, a local district must have several alternatives to pursue. Under certain conditions emergency suspensions can also be initiated, but they cannot be abused, and local policy must be established to limit their use.

A further issue in discipline is corporal punishment, which is governed by state and not federal law (Flygare, 1978). If it is permitted by a state and if members of the interdisciplinary team and parents feel that it would be an appropriate disciplinary tool, then the conditions, circumstances, and type of corporal punishment to be used should be listed on the IEP. In few cases, however, is corporal punishment considered appropriate.

In summary, it is apparent that school districts need to develop and implement disciplinary procedures especially for emotionally disturbed children. By stating in the IEP the types of consequences and punishments, if any, that are to be used with an individual student for misconduct related to emotional disturbance, the procedures are outlined in advance and all parties are protected.

## Related Services

Providing related services for emotionaly disturbed students, as well as for students with other handicaps, is controversial because of the potential high costs associated with them. Related services are defined in PL 94-142 (Reg. 121a.13) as transportation and such developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, and medical and counseling services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a handicapped child to benefit from special education, including the early identification and assessment of handicapping conditions in children.

In terms of related services, most professionals feel that emotionally disturbed children could benefit from some type of additional counseling

services, but no data exist to indicate how much, of what type, and for what duration. Typically, these services are long term and there is no limit on the demand for the service.

A major concern about related services is whether mental health services include psychotherapy and psychoanalysis. Many cases have been heard by OCR, SEAs and SEP in the last few years. In response to questions from the field, SEP developed a policy for review which stated that if evaluation results indicated a need for related services, then the related service must be listed in the IEP and provided without cost to parents. This specifically included counseling, psychological services, and mental health services. Each state was given the discretion to determine eligibility standards, with the exception that if residential placement were the appropriate educational program, then mental health services must be provided. Ordinarily they are not provided in a residential facility because in such a facility mental health services are seen as "medical care" (EHLR, Supplement 28, July 25, 1980, AC 20).

This policy will have far-reaching implications if it is adopted, and "unless the policy conclusion is completely reversed in the subsequent version, it appears that educational agencies will be required to provide psychotherapy as a related service under the appropriate circumstances" (EHLR, Analysis and Comment, Supplement 28, July 25, 1980, AC 20).

At present there are no guidelines that assist in determining when related services are necessary so that a handicapped student can take full advantage of his or her educational opportunity. Without limits or criteria, requests for such service can easily exceed a school district's ability to provide them, and with special education budgets already stretched to their limits, this additional service will be a great financial burden.

Despite the lack of specificity and the confusion, PL 94-142 and Section 504 have improved opportunities for emotionally disturbed students to receive a free, appropriate education in the least restrictive placement. Such students can no longer be summarily excluded from school nor can their educational needs be ignored. The public schools, while resistant to change, have made major modifications over a few short years (1975-1981) in the service delivery systems to accomodate these students.

On the other hand, the legislation, with its cumbersome regulations and underfunding, has frustrated everyone. For the local special education administrator to survive, he or she must exert tight managerial and organizational control to develop and maintain a legal program with ever-tightening budgets. These constraints effectively squelch most creative and imaginative problem solving and program development, and create the notion that all special education administration is concerned with only technical compliance. The next section suggests some positive responses to this professional dilemma.

# Program Administration

The importance of the administration in the success of special education programs is often overlooked or misunderstood by parents and other professionals. In addition, there is very little information in the literature regarding the leadership role played by administrators. This section deals with important aspects of a well-administered program and provides specific examples relating to programs for emotionally disturbed children.

## Philosophy

The special education administrator must establish a clear philosophical base to guide program decisions and development. Without clear statements of values, programs tend to disintegrate into loosely joined, highly variable, individual efforts. It is not uncommon to visit a school system and observe staff members operating programs with almost no coordination from program to program, class to class. One classroom may be highly structured, while another may be a random assortment of techniques and materials. One may stress academics and another may stress behavioral control. To prevent such disarray, the teachers, parents, regular building administrators, and related service personnel must know the professional direction the program is following and must know their contribution to that program.

The development of a program philosophy should not be a unilateral activity, but should involve a broad range of interested persons and should reflect state-of-the-art information and trends, coupled with knowledge of legal requirements. The critical skill required of the administrator in this process is the ability to identify the important opinion makers and stakeholders in the community, bring them together with appropriate information, and gain consensus on the values to be pursued by the program.

The philosophy should be clearly articulated in statements that include direct service goals as well as provision of inservice and support to regular education and that specify parent involvement. An example of a specific philosophy presently in use follows:

- Providing a comprehensive array of instructional and related service options to provide a free and appropriate education for all handicapped children from birth through 21 years of age. Such services should be arranged on a continuum of restrictiveness to assure meeting the individual needs of children who have mild through severe handicapping conditions.
- Providing a systematic support system to regular education, designed to help it manage and teach a broader range of individual differences. Such support should be aimed at mainstreaming children in the regular classroom and preventing undue labeling and segregation of children. It also should aid in the integration of children who have been in more segregated settings into the regular classroom.

- Supporting and complying with State and Federal laws governing the delivery of educational services to children with handicaps.
- Acting as an advocate for children with handicapping conditions and their parents.
- Working as a cooperating partner with regular education, community groups, and other agencies to maximize services to children with handicaps in order to reduce duplication of effort.
- Working closely with the parents and families of children with handicaps to assure a cooperative, understanding atmosphere in the joint pursuit of appropriate service systems.
- Developing a quality, large city program that can serve as a model for urban services. Such a program should seek to incorporate the best professional thinking and practices in its design and implementation.
- Providing ongoing educational opportunities for parents and professionals to assure the continuing upgrading of skills and information necessary for program improvement.
- Establishing evaluation mechanisms for describing and measuring positive student change as the primary intended outcome of all services and using such information to modify individual and system programs to meet that end.
- Providing services in the most normal kind of setting possible for all children and preventing unnecessary segregation of children, that is, least restrictive environment.
- Utilizing the regular education curriculum and feeder pattern as a base to establish specialized programs for children with handicaps.
- Viewing children with handicaps as part of a larger environment, that is, an ecological model. Sometimes the environment, rather than the child, may need to change.
- Viewing laws, policies, and regulations as variables to be modified if they do not support these philosophical directions. Funding sources—local, State, or Federal—will be actively pursued to support these directions.
- Considering that children with handicaps are children first and handicapped second, and consequently should have the same rights and opportunities as all children.
- Developing individualized aproaches to educational services.
- Designing programs based upon the educational needs of children rather than on disability categories.
- Preventing practices that tend to stigmatize children in undesirable, stereotyped ways.
- Encouraging normal individuals in society to understand and accept individuals with handicaps as a normal environmental situation and to react in healthy and supportive ways.
- Providing programs to prepare students to be successful members of society both socially and vocationally.

While such statements are broad, they represent the standard against which more specific goal statements for individual program areas such as emotional disturbance can be measured. Program development activities can then be constantly reviewed in light of consistency with overall program goals and direction.

## Policy Development

Once a program philosophy is established, it is important for the administrator to establish and gain support for departmental and district policy—or a set of rules and guidelines. Policy, along with accompanying procedures, provides the daily guideposts for the implementation of the philosophical direction. Policy is more specific than the philosophy and clearly specifies behavior expected of every staff person in the targeted policy areas.

The importance of this function cannot be overemphasized. Without a body of policy sanctioned by the highest levels of authority, staff may act in arbitrary fashion—in many instances contradictory to the values established. Administrators of special education programs often complain that principals do not cooperate or that personnel policies impede recruitment or that some other unit in the system acts in an obstructive fashion. These kinds of problems can usually be traced to a lack of effective policy about special education. Once policy is established by the school board or the upper administration, every worker is bound by that policy until it is changed.

Major issues in need of policy development have already been noted. Such areas as definition of emotional disturbance, identification processes, provision of related services, models of intervention, discipline, and evaluation require policy and procedures if a program is to operate effectively, efficiently, and consistently.

## Recommendations

Because much of the referral and evaluation activities occur at the building level and involve a number of building level staff, there can be room for error and misunderstanding. Consequently, it is necessary to develop and prepare in writing specific guidelines that detail all procedures, including team composition and roles, due process rights and notice to parents, critical forms for the control of the process, and definitions of eligibility.

As in philosophy development, policy development must be an open, enlightened process. The administrator should encourage wide participation in the process and insist on the most current and relevant professional information being available for each area in need of policy. Only through such a process can policy be established that has wide support

and is useful in wide applications. Again, the key skills here are gaining public consensus, awareness of the issues in need of policy making, and a thorough, professional knowledge of current trends and best practices in the field.

While having clear policies and procedures for program operation does not mitigate the need for careful and sensitive communication at all levels, it does prevent misunderstandings and confusion that can lead to serious conflict and interpersonal difficulties. Working with emotionally disturbed children, whether as a principal, teacher, parent, or special education director, is at best a stressful endeavor. Tempers tend to be short and frustrations many. Clearly defined expectations and guidelines for action can avoid a "reactive" situation and can assist others, such as teachers or principals, in planning their own programs of developing alternatives consistent with general policy. Sound policy clears the way for more productive communication, such as prevention and program improvement. Continuous hassles about "what is" prevent pursuing "what can be."

## Program Design

Armed with knowledge about the issues, and experience and training in operating programs for the emotionally disturbed, what is a reasonable program for an administrator to establish? This question is difficult to answer because there are few data to support the effectiveness of the various administrative and instructional options for these services. The local district, however, must establish a service delivery system that meets federal and state requirements and at the same time operates in a flexible, responsive manner to meet both the concerns of the staff and parents and the demands of the local budget. Naturally, it also must be consistent with district philosophy and policy, as noted above.

The first task in designing a program for emotionally disturbed children is to develop an overall, comprehensive service delivery model for the special education program. This model should be generative and inclusive of many specific classroom or support options. One of the most accepted and useful conceptual models available to the field is the Cascade of Education Services model developed by Deno (1970) (Figure 1). This model provides for a close and logical link between special and regular education and accomodates the least restrictive environment requirement. Many modifications of this basic model exist.

The Special Education Continuum Services Model (Figure 2) depicts one such modification. The continuum of services includes the aggregate of educational and psychological interventions for the emotionally disturbed student, beginning in the regular class and moving through self-contained classes and services. In the following description of this continuum, emphasis will be on those sections of the model most relevant to the emotionally disturbed student in a public school setting. Service op-

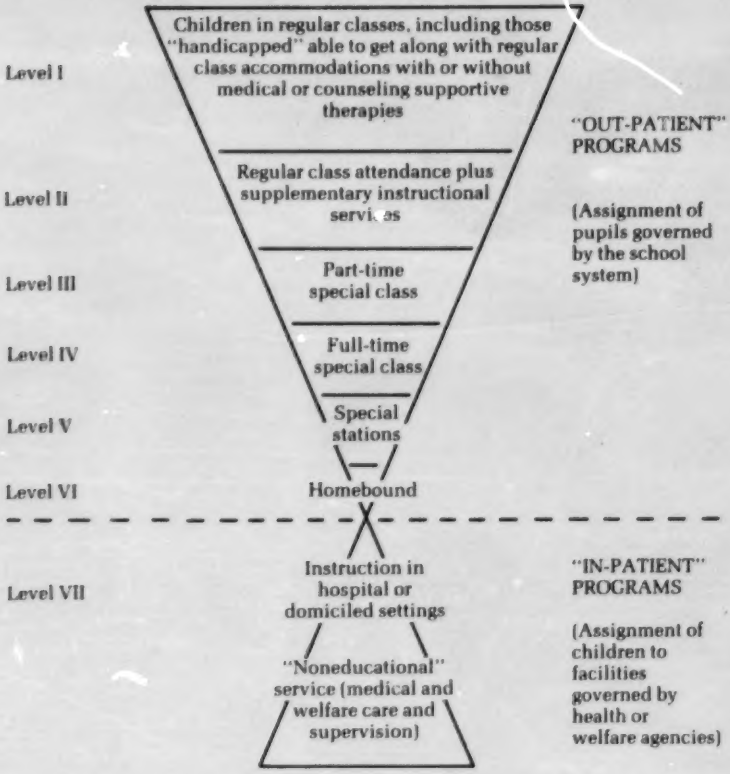
Level I
Children in regular classes, including those "handicapped" able to get along with regular class accommodations with or without medical or counseling supportive therapies
"OUT-PATIENT" PROGRAMS
Level II
Regular class attendance plus supplementary instructional services
(Assignment of pupils governed by the school system)
Level III
Part-time special class
Level IV
Full-time special class
Level V
Special stations
Level VI
Homebound
Level VII
Instruction in hospital or domiciled settings
"IN-PATIENT" PROGRAMS
(Assignment of children to facilities governed by health or welfare agencies)
"Noneducational" service (medical and welfare care and supervision)

Figure 1:
Cascade of Education Services

The cascade system of special education service. The tapered design indicates the considerable difference in the numbers involved at the different levels and calls attention to the fact that the system serves as a diagnostic filter. The most specialized facilities are likely to be needed by the fewest children on a long term basis. This organizational model can be applied to development of special education services for all types of disability.

*Note*: From "Special Education as Developmental Capital" by E. Deno, *Exceptional Children*, 1970, *37*, 229-237. Copyright 1970 by the Council for Exceptional Children. Reprinted by permission.

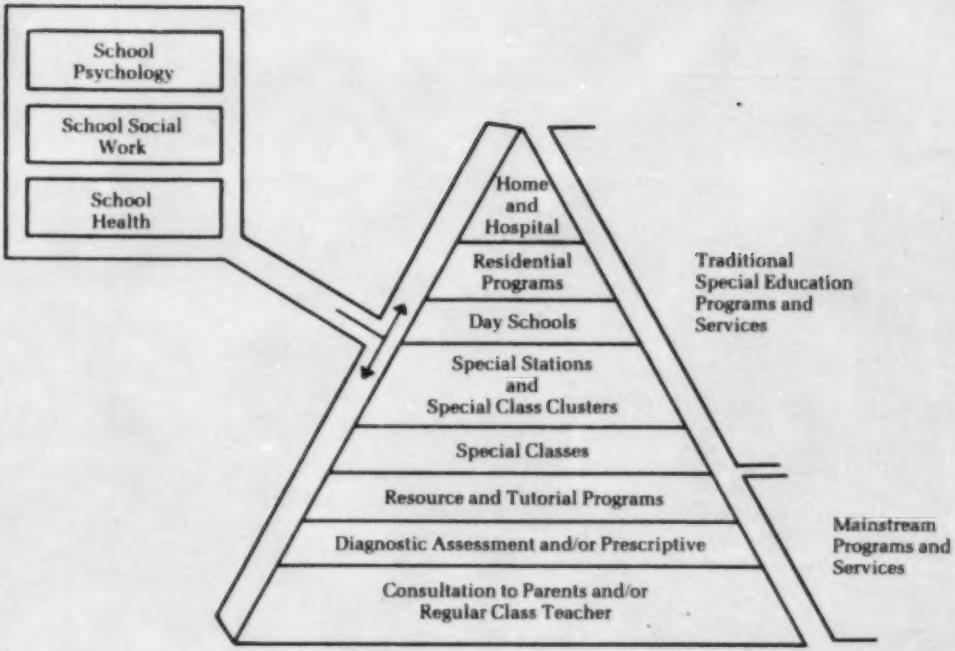


Figure 2:
Special Education Continuum of Services Model

tions for students with more severe behavioral difficulties that necessitate placement outside the regular public schools will not be covered. No attempt will be made to isolate the precise point in the continuum where service for the mildly emotionally disturbed student begins, as this point will vary from school district to school district and ultimately will be determined by individual educational needs. For example, some districts take the position that students who have emotional difficulties must be served exclusively in self-contained classes, while other districts provide such services to these students, at least initially, within the context of the regular class.

The reader is encouraged to make the distinction between mild, moderate, or severe in relation to his or her own circumstances or experience.

## The Continuum Reviewed

### Level I: Consultation

The continuum of services begins with the preventive service of consultation, and may be delivered by any member of a school support team to teachers within the regular class before a youngster is identified as having a handicapping condition. The school support team traditionally includes a school psychologist, a school social worker, a guidance counselor, a special education teacher or supervisor, and the principal. The consultation level is not necessarily child centered nor is it category specific. The focus on this level of service is on the study of the relationship and adjustment of the student to the educational environment. In the past, educators have too often concluded that if a youngster were not learning or behaving properly, the problems resided within the child. In the consultation level of service, attention is paid to behaviors of the teacher, the physical environment, and the dynamics of social structure in the class—all of which could contribute to an individual student's behavior problems.

Under the consultation process, activities of the school team members may include classroom observation, review of student records and classwork, and discussions with the classroom teacher and other members of the school staff. At this level there is no testing, formal interviewing, or direct work with the student. Again, emphasis is on an analysis of the factors in the educational environment which are affecting learning and behavior of the student. The outcome(s) of consultation should provide the teacher or parent with constructive suggestions for remediating the student's behavioral problems without the team members' providing direct services to the student. The first level of service in the continuum is not a traditional part of the special education program because it is preventive and indirect, but it needs to become a standard offering in our schools.

When consultation or indirect service does not solve the student's problem, a second level of service, still preventive, may be necessary. This level is designed to accomplish a broader and more in-depth study of the problem.

## Level II: Informal Assessment

This level of preventive service requires parent permission and a greater level of parent involvement and responsibility. The intent of informal assessment, as with consultation, is to allow the emotionally disturbed student to receive maximum benefit from education in the regular education environment. Often, this means suggestions from the team to the teacher in areas of instruction, teaching strategies, or classroom management. The outcome of informal assessment may also result in suggestions to the parents or to the student in behavioral, social, and academic areas.

The activities of informal assessment include direct interviews or discussions with the student, observations of the student in various school settings, and review of the student's records and work. The team does not engage in any testing of the student at this level.

The team's social worker and guidance counselor have a major responsibility for actively involving parents in the process. The social worker meets with the parents and discusses their goals and/or expectations for the student, their perception of the problem, and behaviors exhibited at home. The parents are apprised of the services of the school team, the process of informal assessment, and what procedures will take place. At the completion of the informal assessments by the team, parents are invited to an informal assessment conference. Results of the assessment are discussed, with emphasis given to the student's need for support within the educational program. The outcomes of this conference may result in the formulation of guidelines for the teacher and parent in working with the student. Definition of limits and clarification of what is expected of the student are made. The social worker or psychologist may be helpful in arranging for parent and child involvement with community agencies. Because the school systems are not staffed with personnel to provide long-term therapeutic assistance, outside agencies are important sources for the provision of such services. Another outcome of the informal assessment process may be a recommendation for non-special-education school services for enrichment or remediation, such as remedial reading or music and art programs.

## Level III: Formal Assessment

The third level of service, formal assessment, is initiated when consultation and informal assessment procedures do not result in the desired behavioral changes. This process includes an assessment of the student's behavioral, academic, and intellectual levels of functioning and should

be consistent with federal law, which requires that assessments be conducted by multidisciplinary teams.

The multidisciplinary team utilizes a broad range of assessment strategies, including interviews with the student and parent, observation of the student in the regular class environment to collect baseline data on the student's behavioral problems, norm-referenced and criterion-referenced testing, and a review of existing school and related agency reports. The assessment model and specific procedures employed are highly dependent on the conceptualization of emotionally disturbed, but frequently the entire process is eclectic. That is, behavioral and traditional psychological assessment procedures are employed. At the completion of the formal assessment, an educational planning conference is conducted. At this conference, the parents of the child, the multidisciplinary team members who have worked with the child, and other school members are invited to attend. An IEP is developed, which may include any of the interventions, including disciplinary procedures previously discussed, and may or may not also include direct services to the student from a special education resource teacher or related services personnel.

### Level IV: Direct Intervention

At this level direct intervention from special education personnel can include resource room service or part-time special class service. Gearhart and Weishahn (1976) delineate the advantages offered to the emotionally handicapped student by retaining the regular classroom placement:

1. The student has an opportunity to observe appropriate behavior of his peers, and interact with his/her peers.
2. The student has the opportunity to experience appropriate expressions of emotions.
3. The student has the opportunity to receive support from his peers.
4. The student has the opportunity to feel that he is more like his peers than different from them.

The resource room can serve as an effective backup to the efforts being made to serve these students in the regular class. A final step in the continuum of services for the emotionally disturbed student in the regular public school would be placement in a self-contained special education class. Wherever feasible, the emotionally handicapped student in the self-contained environment should be included in classes and activities in the mainstream. For those students in the specialized environments, progress should be closely monitored so that they may be returned to the mainstream as soon as appropriate.

## Intervention Strategies

Within the framework of the range of service options, the administrator

may incorporate any number of specific instructional approaches to working with emotionally disturbed children. One example of the interaction possible between the range of services concept and a specific approach is the Madison School Plan, developed in the Santa Monica School District in California (Hewett & Forness, 1977). The plan calls for organizing the education program in one learning center with several different instructional settings, based upon the functional learning needs of the children. This model deemphasizes traditional disability categories as the basis for grouping and organizing services.

The model designates four settings based on assessment of the child's readiness for regular classroom functioning. These settings are Pre-academic I, Pre-academic II, Academic I, and Academic II. Note that the *settings* are labeled, not the child.

## Pre-Academic I

This setting in the learning center is the most intensive and highly structured and stresses the most fundamental of adaptive skills related to successful integration. Such skills as sitting in seat, following directions, taking turns, getting along with peers, and functioning in group instruction are taught in this setting. There is little time spent in the regular classroom for this group, but behaviors leading to that option are stressed.

## Pre-Academic II

The emphasis in this setting shifts to academic skills. The children work in groups of six to eight and are encouraged to work together and to cooperate. This section works on social interaction and participation in group lessons. Integration occurs for each student for some amount each day.

## Academic I

This is a simulated regular classroom setting for 12 to 25 children who require some special attention for academic problems, but can be maintained in a large classroom setting. Group discussion, group lessons, and independent study resemble the regular classrom, but increased emphasis is placed on skills needed for regular classroom placement.

## Academic II

This is a regular classroom setting including 28 to 35 students. Students from Pre-academic II and Academic I grades are integrated here for varying amounts of time.

This operational model for serving emotionally disturbed children in

public schools and the conceptual range of services concept are quite complementary. This accounts for the model's popularity in many school districts. Figure 3 illustrates the interaction of the general model with the specific learning center model.




Figure 3:
Special Education Continuum of Services Model

## Instructional Methodology

One of the special education administrator's responsibilities in terms of policy development is to reconcile the differences in treatment intervention philosophies as they apply to the emotionally disturbed. Some areas of the country are heavily influenced by psychodynamic philosophies and practices, while others are more convinced that operant behavioral approaches are more effective. In between are numerous other treatment approaches that may incorporate reality therapy, transcendental meditation, life-space interviewing, group encounters, transactional analysis, values clarification, and other popular treatment systems, many of which are derived from basic personality theories.

The controversy over intervention models became apparent almost two decades ago, with two models that could not have been further apart. The basic controversy is referred to as the "internal deviancy" versus the "behavioral" model. The chief characteristic of the internal deviancy model is its emphasis on internal factors as major sources of symptomatic behavioral or learning deviancy. The behavioral approach, in contrast, focuses on present environmental events and the effects these events have on the child's learning and behavior (Gardner, 1977). While today there are programs that adhere to one model or the other, more often programs incorporate some strategies from both. Examples of these two models include the Berkowitz and Rothman (1960) model, the "600" schools in New York City. They maintained that behavior problems occurred when the internal conflict of a child was resolved by the acting-out of the conflict in an unacceptable way. To deal with this acting-out behavior, they advised that the atmosphere of the classroom should be *permissive*, with students working on their own projects (academic or nonacademic), secure in the knowledge that what they were doing would be looked upon with approval and would be of value to the teacher and peers. The teacher in this setting was not concerned with skill acquisition or discipline, but with "teaching" emotions. Teachers in this model were told to accept the behavior of the child in the class no matter how unacceptable that behavior might seem to be. The teacher would accept aggression and not pressure withdrawn students into socializing. Clinical judgment regarding needs as well as program effects were utilized.

At the other end of the continuum, Haring and Phillips (1962) had developed an empirically based *structured* classroom program that they felt was beneficial to the student's emotional as well as academic growth. In their model the emotionally disturbed child was given clear directives based on firm expectations. Intervention included academic instruction and behavior management. Consistent follow-up was mandated to let the student know that expectations would hold from day to day and these expectations in instructional tasks were structured to provide the student ample opportunity to earn success, the foundation upon which the program was based. Emotional upsets were handled in a matter-of-fact "back to work" manner. This latter method was a clear signal that if these emo-

tional upsets were responded to with warm, accepting, kindness the teacher would, in effect, be reinforcing these behaviors and they would continue to occur.

The problem created by divergent philosophies such as these arises when teachers from a wide variety of training programs emphasizing different approaches come together in a single place. It becomes very difficult to develop a consistent philosophy and treatment approach under these conditions. Teachers trained under one specific instructional philosophy have deeply ingrained attitudes that their approach is the best, and if administrators want to adopt one consistent instructional approach for the district, they meet strong resistance.

Administrators, however, have tended toward behaviorally based and data-based instructional systems because they are more accountable. These systems that clearly or operationally define the target behaviors for intervention and that specify the conditions under which such behavior will have to occur have a better opportunity to measure the degree to which a program or intervention was or was not successful. All parties—teacher, student and administrators—know when the instructional techniques are working because measures of their success can be consistently monitored.

The need for accountability and program evaluation is more critical than resolving philosophical differences. By focusing on specific child performance data, the effect of instructional methodologies may be determined, and those that are successful can be incorporated into policy.

Once the major tasks of developing a departmental philosophy, establishing operational policy, and designing the overall service delivery structure are completed, the next steps of successful administration involve the conscious design of a management system. Without such a system the administration of programs may merely become a series of problem-solving episodes.

## Principles of Management

In reflecting on the variables that seem to account for the differences between successful and unsuccessful management of special education programs, several basic principles stand out: priority setting, organizing for change, setting and managing objectives, training for excellence, evaluating, and using of politics.

### Priority Setting

In setting priorities it is important that the tasks required by law and policy be tackled first. It is a maxim that one must do what *has* to be done

before one can do what one would like to do. This maxim is not always a popular one to follow. Professionals would rather be involved in the exciting, innovative program development activities. Parents want immediate upgrading of the curriculum and instruction for their children. Still, when the "musts" are neglected, conflicts begin to increase. Thus, it is important to involve a broad range of individuals, including parents and general education administrators, in the priority setting process.

It has been estimated that there are over 400 compliance requirements in PL 94-142; only a few of these resultant dilemmas have been addressed in this paper. A district must plan well for meeting these "musts."

## Organizing for Change

Typical organizational charts or schemata for special education structures emphasize the day-to-day operational functions. The system chosen can reveal much about the philosophy and direction of the unit. For example, if administrators are assigned to categorical responsibilities (e.g., Supervisor of Programs for the Emotionally Disturbed), then the district probably focuses its services and delivery model categorically. There will likely be classes for mentally retarded children, for emotionally disturbed children, and for other disability categories. If administrators are assigned by level (e.g., elementary, secondary) or by generic categories (e.g., mildly handicapped, moderately handicapped), then it is likely that the program delivery focuses more on the functional needs of children than on assumed needs associated with the disability categories.

Another way a district can organize is to focus on the critical tasks to be accomplished at any given time. In this system, the organizational structure is fluid in order to meet the changing conditions of the district. It is very difficult in a large special education program to make significant changes while continuing to run the current program.

For example, in one school system in which one of the authors was involved, a major weakness existed in the program for emotionally disturbed children. The program was categorically based with heavy emphasis on self-contained classrooms. Children were grouped simply by label, not by assessed level of needs. Teachers were poorly trained, and had no consistent professional orientation toward the program. In addition, they generally had low academic and behavioral expectations for the students. The program emphasized crafts, free reading (usually of pulp-type magazines), and permissiveness. Behavior management tools such as contingency contracts were not evident, nor were instructional programs. The program resembled a school-based halfway house. Needless to say, this situation produced constant conflict and frustration. Over time, principals refused to have such programs in their buildings. Administrators moved from one crisis situation to another, and there was no time to analyze the problems. There were also problems in other areas, chief among

them noncompliance with federal and state laws. At the peak of frustration the head administrator of special education was fired and a new individual was hired.

The new administrator immediately saw that there would be little chance of altering the situation without a major organizational change. Without increasing the number of management positions, the administrator created two major branches—one for operations and one for program development. Program development became the organizational change unit. Its staff conducted surveys and studies necessary to analyze the extent and nature of the problems; they brokered services from the local universities and colleges to help plan new approaches; they wrote grants to help with staff training; and they worked to develop a computer-based data system for management. In the meantime the operations division kept things running and was even able to improve on efficiency of operational practices.

The units worked closely together to assure coordination, and over a period of two years, many curricular and instructional changes were instituted without major interruption. This structure is still in operation and probably will remain for three to five more years, when most of the changes will have been completed; at that time another structure may be needed.

The key point of this discussion is that the organizational structure in and of itself should neither be overlooked in the development of educational programs, nor should it be considered inviolate. Instead, it should be considered a variable, capable of redesign whenever the organizational tasks require such action.

## Setting Objectives

Once a philosophy is established and major priorities determined, the process of setting specific objectives to guide the year-by-year work needs to begin. This step is often missing in programs that are in trouble. Usually, philosophy and priority statements are too broad to be useful in the actual management of the organization; therefore, the broad statements need to be refined or task analyzed. The work has to be clearly specified as outcomes, and time and resources (e.g., personnel) have to be assigned to objectives.

Again, it is helpful to involve a broad base of interested parties in setting work objectives, especially the staff who are expected to carry out these objectives. Input should be gathered as to the work to be done first. This input is then sifted, evaluated, and considered in relation to priorities and philosophy. The work objectives are then rank ordered in terms of importance, and those that can be accomplished within a specified period of time, usually a year, are chosen for further development.

First, the broader objectives of the department are developed to guide in-

dividual administrators in developing their own unique work plan. Departmental objectives should be stated broadly enough to allow considerable flexibility for individuals, but clear enough to have specific observable outcomes.

An actual example of objectives dealing with disciplinary problems of handicapped students follows:

A. The Department of Special Education will analyze and revise present procedures for dealing with handicapped students who are disruptive, explore new alternative procedures at the building level, and provide direct services to staff and parents on disciplinary alternatives. Specifically, the department will do the following:

   1. Revise the guidelines for disciplining students with handicaps so that they conform to legal requirements and allow for flexibility and staff judgment.
   2. Develop alternative strategies with school principals for handling disruptive behaviors at the building level.
   3. Develop plans for the implementation of inservice training in dealing with disruptive behaviors. This will include training for all staff in a building, including kitchen and meal service personnel, school secretaries, bus drivers, custodians, and any other staff at the building level.
   4. Provide direct service to building staff based upon revised guidelines, principals' recommendations, and inservice training plans.
   5. Provide direct services to parents in the form of group classes on behavior management.
   6. Provide individual consultation to a limited number of families (10) and relevant staff.
   7. Continue community referrals when appropriate, and produce a resource directory for referring families and staff to appropriate services.

   Procedures that *may* be used include:

   1. Establish a task force of principals to study the problems and propose recommendations.
   2. Plan alternative strategies to handle disruptive problems. One approach is the submission of a grant application to fund a three-year demonstration project for secondary level children with behavior disorders.
   3. Develop a model/demonstration classroom at the elementary level for disruptive children.
   4. Increase inservice training to staff on disciplinary procedures and program options for handicapped students who exhibit inappropriate behavior.
   5. Work with community agencies to identify solutions to these problems.

B. Evaluation of this goal will have both process and product components. Products include: new disciplinary guidelines for the district, tangible results from work with other community agencies (e.g., submission of grants), and recommendations from the principals' task force.

   The processes that are used will be reviewed by the director to determine 1) if input was received from representatives of concerned staff, and 2) that those

most closely involved with disciplinary decisions were included in revising the guidelines and in developing alternative plans and inservice training plans.

The net effect of this goal is to increase the staff's ability to handle disruptive behavior and to have procedures for changing the educational program and/or placement of a handicapped student that are in the best interest of the student, meet federal and state regulations, and provide for maximum use of staff judgment and flexibility in implementation.

C. Review of the work plans: The director will meet monthly or more frequently, as needed, with the managers of the department to review the work plans for this objective.

Individual supervisors and administrators were then charged with developing parts of this objective within their own area of expertise or responsibility. The work was coordinated among administrators and the result was a comprehensive solution for dealing with discipline issues across all programs. Specific policy, classroom procedures, and staff training programs were developed and implemented.

## Managing Objectives

It is not enough to set objectives. They also must be managed. One criticism often made of the process of developing objectives is that they sit on the shelf and are never utilized. Monitoring of objectives should include periodic reviews to evaluate progress toward the objectives. These should occur at least quarterly and should result in clear, unambiguous statements regarding the status of each objective. Such a process keeps the departmental work on track, allows time for corrective action when things go wrong, allows for help to be given, and keeps staff from being surprised at the end of the year.

## Communication

Much has been written regarding the central role of trust in a successful organization. Quality communication is that which communicates an idea, sincerely invites input, and feeds back how the input was utilized. People need to feel that they have a stake in the organization and can influence its directions and activities. Effective communication enhances these feelings and leads to more interested participation.

In successful programs, the staff have a unified sense of the direction and philosophy of the organization. They may not always agree with the thrust, but they know what it is. The administrators of these organizations almost compulsively involve and communicate with staff. They develop creative newsletters that invite response, meet face to face with staff to apprise them of major issues that affect them, and always emphasize two-way communication. They ask for and use staff input.

## Training for Excellence

Another characteristic of successful programs in special education is the importance given to inservice training and staff development activities.

With reducing enrollments and generally hard economic times, there is much less population mobility and job changing. The result is often an aging, undertrained staff without the skills to implement innovative ideas. This factor is compounded by teacher association contracts that require seniority as the basis for transfers, placements, and layoffs. The administrator is practically helpless to staff programs with the most appropriate persons. This can result in devastating damage to otherwise sound programs. The most positive way to deal with these situations is to develop a comprehensive, ongoing training program for all staff to assure that the skills necessary are developed.

Also, with the technology and knowledge explosion, teacher skills are out of date much sooner than before. Training programs are no longer a luxury; they are absolutely critical to survival. Successful administrators know this and have worked to incorporate training as an integral, long-term part of their special education programs.

## Evaluation

Successful programs are serious about discovering how successful they really are. Much attention is given to the collection and analysis of data that have relevance for program decisions. Data need to be collected at several levels.

The most basic and ultimately most useful level is the classroom. Teachers need to use efficient data collection systems to answer key questions as to the effectiveness of their instruction and interventions. The whole purpose of special education is to produce positive academic and social behavioral changes. It is surprising how many programs, maybe even most programs, place little emphasis on measuring student change, except perhaps in the crudest forms. Admittedly, this is a touchy area. Unions quickly get involved when teachers are required to keep data on students. Only when the teachers themselves see the value of the data will they support the effort and make it successful. This means the system chosen must be relevant to instruction, efficient, and have demonstrated usefulness. If the data collection system meets these requirements, staff will be more likely to cooperate.

Data also should be collected on attitudes, validity of models, successful instructional strategies, and variables related to broad management needs such as parent satisfaction and cost effectiveness of various programs. Armed with up-to-date information on all aspects of the program, the administrator is secure in making decisions and can counter criticism in controversial areas.

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## Politics

In its broadest sense, politics must be constantly considered if a program is to survive. No program or administrator operates in a vacuum. While special education has often been accused of being a separate school system with its own rules and budgets, it is changing rapidly. With the emphasis on least restrictive environment, special education administrators must attend to the social and political interactions in and out of the district.

The natural overlap of responsibilities between building principals and special education program managers is a constant problem. Who is in charge? Only through productive dialogue can this question be resolved. Is special education a line or a staff organization? Do special education students get too many rights and privileges? Are normal children neglected? The questions come incessantly. The administrator must develop excellent relations with the persons or groups who ask these questions, and work with them, both to increase their understanding and tolerance as well as to assist them in carrying out their own responsibilities. The administrator must be an enlightened advocate. Intemperate demands will result in rejection by the regular education forces. Insufficient demands will result in parent dissatisfaction. The successful administrator must find a way to walk a fine line between conflicting philosophies, while maintaining the quality of the educational programs.

## Summary

No program exists in isolation. Successful program administrators must see themselves as part of a large, interdependent, and even international program development activity. Special education is, in a sense, a relatively new field. Certainly since the passage of PL 94-142 the field has achieved a legitimacy and visibility unknown before. With increased visibilty comes increased responsibility. In terms of progress for emotionally disturbed, there are problems. There are few validated models or proven approaches. Program development involves a constant search for the best and then adapting it into existing systems.

Administrators are not only faced with developing effective programs, but also with the task of ensuring that these programs meet all legal requirements. The outcome, quality education for emotionally disturbed children, is achieved only through careful management coupled with attention to needs and priorities of the regular educators, parents, and community members. It is unreasonable to suggest that the process is any more complex for the emotionally disturbed than for other handicapping conditions. Administering special education programs is, in general, a tough job. But only through attention to administrative concerns can we significantly alter the lives of troubled young people in the educational system.

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